# The Public Health System in England: a Scoping Study

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# Contents

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# Acknowledgements

# 1. Introduction

The specific purpose of this scoping study of the public health system in England is to provide essential, and hopefully helpful, background and context for the National Institute for Health Research Service Delivery and Organisation's (NIHR SDO) new public health research programme. It is intended to be of use to the successful proposals selected for funding (for summaries of the studies visit www.sdo.lshtm.ac.uk) and to avoid individual research teams having to rehearse much of the background to public health policy and practice, both past and present. The scoping study has been produced in two parts.

Part 1 reviews the state of the public health system in England in terms of its structure, capacity and skills. An earlier version took the form of an interim report to the SDO, submitted in January 2007, and was timed to be of assistance to those researchers who had been successfully selected to proceed to the second stage of the application process. Much of the interim report, now integrated into this final report as Part 1, concentrated on the historical development of public health since 1974 and adopted the notion of a public health system as an organising device to bring together the various sectors – statutory and non-statutory – that contribute to the public's health.

Part 2, based on a series of in-depth interviews specially conducted for the scoping study, reviews the current state of public health and assesses the impact of the current changes in policy and structures on the public health system and their implications for its future design and effectiveness.

The boundaries of public health, and therefore of a public health 'system', are notoriously difficult to define with any precision. They are amoeba-like and influenced by changing perceptions of the factors which impact on health and shape health inequalities, of the methods considered to be effective in addressing public health issues, and of the overlap between the public health 'system' and broader social, environmental and economic activity.

We subscribe to the Institute of Medicine's conceptualisation of a public health system to describe 'a complex network of individuals and organisations that have the potential to play critical roles in creating the conditions for health' (Institute of Medicine 2003). Even so, adoption of the term 'system' to describe what remains a rather chaotic, sprawling, dynamic, and often intensely political, activity that seems more closely to resemble a non-system might appear odd and is certainly open to debate. But, perhaps precisely for these reasons, there is now more interest than has been evident in the past in trying to define with greater clarity what such a system comprises and seeks to do. This is especially the case when, as Kickbusch (2007) points out, the so-called 'health system' has rarely been concerned with health but largely with ill-health.

We have adopted an inclusive approach to the notion of a public health system and take it to embrace both those organisations formally charged with taking forward the public health policy and delivery agenda, notably the NHS, local government, and regional agencies, but also the non governmental agencies engaged in lobbying and

campaigning in respect of various public health causes and issues, such as child poverty, smoking and the provision of contraceptive services. They have had a significant influence on health policy and on public policies which influence health. We discuss the public health system and its underpinning values in more detail in Section 3.

Compounding the problem of defining the public health system, the public health community in England has lacked a clear conception of its purpose and *raison d'etre* and, perhaps as a consequence, has been subjected to a considerable degree of change and uncertainty, especially from 1974 onwards. These changes have invariably not been directed primarily at the public health community but have nevertheless had a major impact on policy and practice at all levels of the system. This is particularly true of those sections of the workforce employed by, or working for, the NHS. At the same time, the policy context in which public health practitioners operate has changed in recent years from one where there was an expectation that government was responsible for leading collective responses to public health problems to one where the emphasis is much more on what individuals can do for themselves enabled by government and other sectors, notably business and more recently the 'third sector'. All these developments have resulted in a public health community that is increasingly insecure and unsure of its purpose and fitness for whatever that purpose proves to be.

The complexities involved in addressing health inequalities and in improving the health of the population are reflected in a wide range of regional and local partnerships which span health services, local authorities, business and, the third sector. In England, these partnerships are underpinned by new and better aligned performance management arrangements. Although partnerships are clearly an essential dimension of the public health system, in most such systems there remain unresolved questions of remit, governance and accountability which all too often undermine the effectiveness of partnerships.  Engagement is increasingly seen as key to an effective public health system. This refers not only to people engaging with their own health or with a wider public health agenda but also to the ways in which a public health workforce, however defined, needs to engage with its public together with a range of other stakeholders.

Given the complexities, and virtually continuous change affecting the public health community in England, a scoping study of how these have impacted, and are impacting, upon the public health function in England is seen as desirable. As mentioned above, its immediate purpose is to provide a baseline for the NIHR SDO R&D Programme's public health research initiative. At one level, having such an account is simply intended to avoid unnecessary duplication or repetition which might otherwise occur within individual research studies. But at another and deeper level, it is hoped that the study will serve a useful function in itself by bringing together into a single document a number of issues which, though linked, are often treated separately and without their implications for public health policy and practice always being fully explored or understood.

The focus of this scoping review is confined to the public health system in England. However, where appropriate and helpful to illustrate a point or draw out a lesson for policy and/or practice, the study will refer selectively to the experience of public

health elsewhere in the UK, notably Wales and Scotland where, post-devolution, greater divergence in health policy and practice is a feature of these respective countries (Greer 2007), although precisely how much divergence is substantive rather than merely symbolic remains to be determined (Blackman et al 2006). Similarly, useful pointers from other countries in respect of how a public health system might be organised and made more effective are mentioned.

# Part 1: The State of the Public Health System in England: its evolution between 1974 and 2004

## 2. Background

The notion of a public health system provides a useful organising device to bring together all the various sectors, statutory and non-statutory, that contribute to the public's health. In Section 3 we outline ways in which this broad approach has been conceptualised. A public health system can be viewed in descriptive and historical terms – that is, as a summary of the organisations and workforce formally involved in identifying and addressing population health needs, the ways in which they interact (or fail to), and how each of these components has changed over time. It can also be viewed normatively in terms of how the elements of such a system might be configured to address factors which influence the health of the public in both the short and the longer term. Any critical assessment of a public health system has to address the extent to which that system, as currently configured, is capable of identifying and addressing both present and projected public health challenges. It is in identifying these challenges and determining the appropriate response in organisational and workforce terms that deep-seated tensions emerge.

In this first part of the scoping review we are concerned with the public health system in both descriptive and historical terms. In Part 2 we explore how such a system might function differently, and possibly more effectively, in the light of changes currently being implemented.

Adopting a descriptive and historical perspective illustrates how locations, responsibilities and systems of accountability in a public health system have changed over time and the benefits and costs of various reorganisations on the effective working of this system. The scoping exercise explores and describes the public health system in England – what it looks like, how it has been defined and understood over time, and the key organisations that go to make it up. The starting point for this review is 1974 when lead responsibility for public health, which had up until then been located in local government, was transferred to the NHS where it has remained ever since. For ease of reference, and to avoid cluttering the main text with the numerous structural changes that have occurred with increasing rapidity since 1974, the various changes are described in Appendix 1. As was asserted in a recent House of Lords debate, 'Nowhere, perhaps, has reorganisation been more disruptive than in public health' (House of Lords 2006).

The evolution of the public health system in England has been underpinned by a number of often overlapping recurring themes and schisms which have shaped public health policy and practice since 1974. Principal among these, and in no particular order, are the following:

- what constitutes public health and how the function is defined
- the optimal location of the public health function
- the relationship between health improvement and inequalities in health

- the population focus of public health alongside attempts to influence individual lifestyles
- the nature and conceptualisation of the workforce both in terms of capacity and capability
- the nature and scope of the public health system
- the balance between collective responsibility and individual choice
- the balance between public health and health care
- public health's advocacy role and corporate identity, ie activist versus 'technician-manager' roles (Berridge 2006: xxiii).

These themes have recurred in cyclical fashion in the evolution of public health since 1974 and they remain contested and largely unresolved issues in current policy and practice.

Part 1 of the scoping review is organised into two main sections. Section 3 explores the notion of the public health system as a way of conceptualising the public health function. Such an approach is finding favour in some quarters and may provide a means of addressing concerns around public health governance and accountability. Section 4 reviews the development of public health since 1974 and focuses on the definition of public health which has served to influence its location and organisation, and the nature of the workforce. It includes a detailed account of changes in the ways that specific aspects of the public health system in England, such as health protection and health education, have been organised.

## 3. The Nature of the Public Health System

In this section we explore different approaches to understanding the public health system. We begin by considering the notion of a public health system as a way of encompassing factors which influence health. This may provide a helpful framework within which to locate the public health function. We then describe a number of different approaches to operationalising this broad concept drawing on examples from England and internationally.

### 3.1 Whole systems approach
The public health system can encompass all factors influencing the health of populations, including proximal causes and social determinants such as social exclusion, poverty, housing or education. To the extent that definitions of health are global, encompassing and aspirational, so the landscape of the public health system expands. The WHO concept of health as a 'state of complete physical, mental and social wellbeing and not merely the absence of infirmity' leaves little outside the potential purview of public health. The definition has been criticised for being naïve, unrealistic and utopian. However, many observers consider that it provides a good starting point (Calman 1998). What it usefully does is imply that health is multi-dimensional and holistic, embracing all aspects of individual and collective existence. A healthy person is one who enjoys a harmonious existence within themselves and within their societal and environmental context.

Showing the main determinants of health, Dahlgren and Whitehead's 'rainbow diagram' (see Diagram 1) has been an influential reminder of the importance of adopting a whole systems approach to public health, the limitations of a downstream approach, and the complex ways that social factors (and ways of addressing them) are interrelated (Dahlgren and Whitehead 1991).  It identifies the range of sectors at both national and regional levels which influence the health status of populations, the sectors across which action would need to be taken in relation to problems affecting the health of populations, and the potential contribution of public health partnerships at both horizontal and vertical levels.

*Diagram 1 The Main Determinants of Health*



Source: Dahlgren and Whitehead, 1991
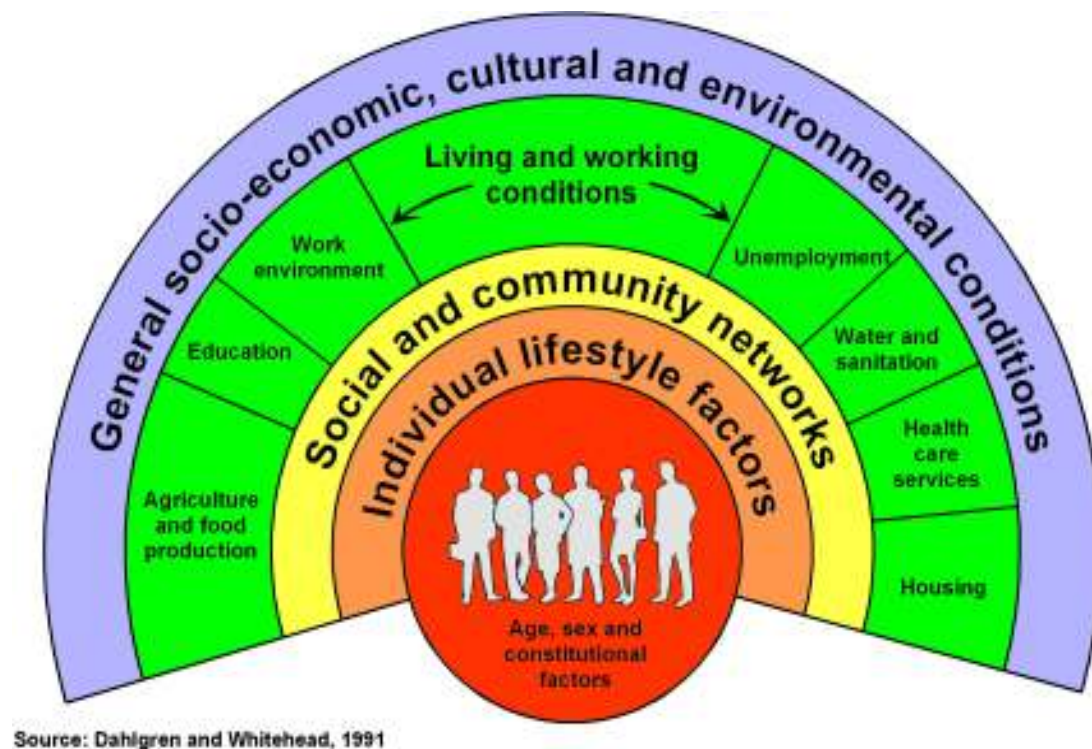
Since the diagram appeared  over 15 years ago, there is increased awareness of health as a global issue and of the current threats to global health, including bioterrorism, climate change and potential pandemics like the SARS outbreak. There is therefore an important (and growing) global element to health protection which should be reflected in a country's public health system (see Diagram 2). At the other end of the spectrum, there is also a better understanding of the factors which can influence wellbeing and positive health

*Diagram 2 Global Determinants of Health*



Source: Based on Dahlgren and Whitehead (1991), amended by Barton and Grant (2006) and the UKPHA Strategic Interest Group

The Dahlgren and Whitehead diagram, and its variant, provide a template against which the breadth and priorities of the public health system can be gauged. It illustrates the difficulties in drawing boundaries around public health systems and shows the levels at which action needs to take place and the partnerships likely to be required although this will vary for specific health issues. It also points to the inevitable tensions between the ways that a formal public health system is constructed and the areas which lie outside it.

The idea of a public health system is not exactly novel and draws heavily on WHO's conception of a health *system* (as distinct from a health *service*) as mentioned earlier in respect of the *Health for All* strategy, Alma Ata and the Ottawa Charter. These initiatives, in turn, influenced the emergence of the 'new public health' movement, healthy public policy (Milio 1981), and social and ecological models of public health which draw on 'whole systems' and complexity thinking (Glouberman 2000; Hunter 2003 and 2007). These models are undergoing something of a resurgence of interest as both an antidote to the focus of much public policy on markets, competition and

consumers, and to a recognition that the public health and sustainability agendas share many of the same concerns and perhaps ought to be regarded as a single shared agenda for action and policy change. A social, ecological and whole systems approach means working in partnerships and collaboratively across complex systems and with local communities and requires the development of new social indicators to match (eg Gillies 1998). The public health system, therefore, is not just a collection of discrete entities and responsibilities. Its effectiveness is indicated by the quality of relationships across them.

**3.2 Approaches to defining public health systems**

The conceptualisation of the 'public health system' put forward by the US Institute of Medicine adopts a more flexible network based approach. The 1988 IOM report conceived of the 'public health system' as encompassing 'activities undertaken within the formal structure of government and the associated efforts of private and voluntary organizations and individuals' (IOM 1988: 42). A second follow-up IOM report expands the notion of a 'public health system' to describe 'a complex network of individuals and organizations that have the potential to play critical roles in creating the conditions for health. They can act for health individually, but when they work together toward a health goal, they act as a system - a public health system' (Institute of Medicine 2003: 28). Whilst acknowledging the crucial importance of government public health agencies, the health delivery system and academic public health, this conception of the 'public health system' also identifies a range of actors in wider society who play an important role in public health. They include 'communities' (encompassing schools, religious and other organisations), businesses and employers, and the media.   The IOM's approach is not especially novel or unique and a similar conceptualisation of the public health system would apply in England, if not the UK. But what is helpful about the Institute's reports is their attempt to describe the whole system in such an explicit manner.  Moreover, by expanding the boundaries of the conceptualisation of the 'public health system' to agents beyond the 'usual suspects', the IOM hopes to put public health firmly on people's agenda, promoting collective rather than individual action:

*Acting alone, persons of means may procure personal medical services and many of the necessities of living. Yet no single individual or group can assure the conditions needed for health. Meaningful protection and assurance of the population's health require communal effort. The community as a whole has a stake in environmental protection, hygiene and sanitation, clean air, uncontaminated food and water, safe blood and pharmaceutical products, and the control of infectious diseases. These collective goods, and many more, are essential conditions for health, but these 'public' goods can be secured only through organized action on behalf of the population* (Institute of Medicine 2003: 22).

The aim of this revised conception of a 'public health system' is to expand the focus on public health to all actors whose actions are likely significantly to influence public health which, taking a social determinants model of health, includes a wide range of individuals and organisations: 'There is strong and growing evidence that 'healthy' public policy must include consideration of domains that are not traditionally associated with health but whose influences have health consequences (e.g., the education, business, housing, and transportation domains)' (Institute of Medicine

2003: 34). A focus on 'healthy' public policy, outlined in the first IOM report is retained but the need to work with multiple actors to achieve the kinds of changes necessary for 'healthy' public policy to work is brought to the fore in the 'intersectoral public health system'.

Although the concept of the public health system can be applied to an almost endless range of sectors, the report's authors select five actors that they feel, 'together with the government public health agencies, are in a position to act powerfully for health'. They have already been mentioned above – 'communities', including schools, law enforcement, and so on; the health care delivery system; employers and business; the media; and 'academia'. The report goes on to outline the rationale for the involvement of each of these groups, both in terms of what they can contribute to public health and what the incentives are for them to take on this role. For example, 'businesses and employers will have healthier workforces and constructive relationships with the community, the media will better serve the public interest, and communities will be active participants and even leaders in their own health improvement process' (Institute of Medicine 2003: 31).

In order for the authors' concept of an effective intersectoral public health system to function, they identify the following six areas of action and change that are necessary:

'1. Adopt a **population health approach** that builds on evidence of the multiple determinants of health;
2. Strengthen the governmental public health infrastructure - the **backbone** of any public health system;
3. Create a new generation of **partnerships** to build consensus on health priorities and support community and individual health actions;
4. Develop appropriate systems of **accountability** at all levels to ensure that population health goals are met;
5. Assure that action is based on **evidence**; and
6. Acknowledge **communication** as the key to forging partnerships, assuring accountability, and utilizing evidence for decision-making and action' (Institute of Medicine 2003: 33-34).

As this list highlights, the role of partnerships is critical to the process of achieving significant public health improvements (see Diagram 3). Elsewhere, the report also places a great deal of emphasis on the importance of community involvement and ownership in taking forward the kinds of changes it hopes to see emerge.

*Diagram 3 The intersectoral public health system*
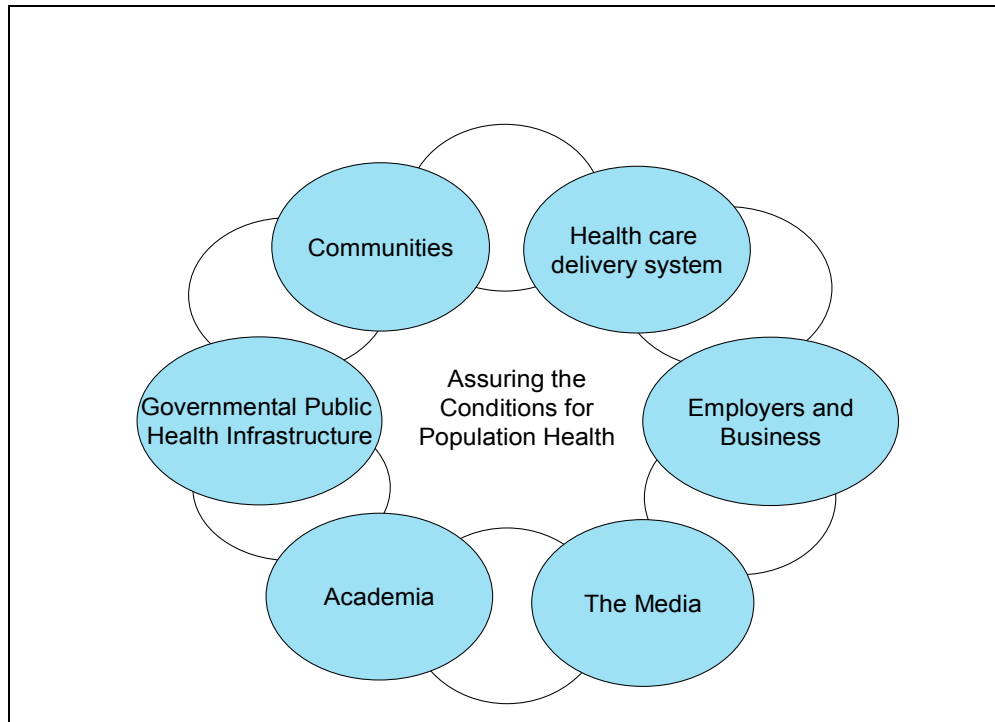


Source: IOM (2003)

The IOM's notion of a 'public health system', by which those involved in public health have attempted to ensure the issue becomes a driving force for action in a wider variety of sectors, has its equivalent elsewhere. In Australia, the New South Wales (NSW) Health Department (2001) has developed the idea of 'capacity building', which it describes as 'the 'invisible work' of health promotion, […] the 'behind the scenes' efforts by practitioners that increases the likelihood that effective health promotion programs will be sustained.' This includes activities as diverse as exploring the opportunities for a particular programme, gathering support for relevant initiatives, developing skills of relevance to public health, supporting policy development in ways which are sympathetic to public health, or guiding the establishment of effective partnerships. As with the IOM's notion of a 'public health system', the aim of capacity building is to increase the range of people, organisations and communities who are able to address health problems by establishing a common goal and purpose amongst a wide group of actors. This approach is similarly sympathetic to the social determinants of health model, aiming, in particular, to address health problems arising from social inequity and social exclusion.

Rather than mapping the various agents involved in the 'public health system', and the roles they might undertake, capacity building aims to develop sustainable skills, structures, and resources for health improvement, across a range of sectors. The aim is that, as well as achieving an expanded commitment to health improvement amongst

various communities and organisations, these various agents also achieve a greater capacity to fulfil their public health role. There is no clear prescription for how this will be achieved. Indeed, capacity building is variously referred to as 'a means to an end', 'an end in itself', and 'a process'. The NSW Health Department accepts that different organisations are likely to have quite different ways of conceptualising the notion. The model outlined suggests capacity building work does exhibit some fundamental features. First, it ought to link key areas for strategy development (organisational development, workforce development, resource allocation, partnerships and leadership) to the following three dimensions: infrastructure development, programme sustainability, and enhanced problem solving. Second, the Department highlights the importance of taking 'context' into account when developing capacity building strategies. Third, although capacity building activity may be developed amongst individuals, organisations or communities, particular emphasis is placed on the importance of developing partnerships between various actors.

There is now a consensus, both in the UK and in other countries, that the challenges facing public health require a multidisciplinary, multi-sector response (Hunter 2003). For example, in recognition of the fact that health status is largely determined by factors outside the domain of health care, the notion of Health in All Policies (HiAP) was the main health theme of the Finnish Presidency of the European Union in the latter half of 2006. The Finnish Minister of Health and Social Services explained HiAP in these terms: '[It] highlights the fact that the risk factors of major diseases, or the determinants of health, are modified by measures that are often managed by other government sectors, as well as by other actors in society' (Stahl et al 2006).

More prosaically, the Department of Health website (2007a) describes the 'modern public health system' in England as including the following 10 core functions:

- Health surveillance, monitoring and analysis
- Investigation of disease outbreaks, epidemics and risks to health
- Establishing, designing and managing health promotion and disease prevention programmes
- Enabling and empowering communities to promote health and reduce inequalities
- Creating and sustaining cross-government and intersectoral partnerships to improve health and reduce inequalities
- Ensuring compliance with regulations and laws to protect and promote health
- Developing and maintaining a well-educated and trained, multi-disciplinary public health workforce
- Ensuring the effective performance of NHS services to meet goals in improving health, preventing disease and reducing inequalities
- Research, development, evaluation and innovation
- Quality assuring the public health function.

Whilst this list suggests that a public health system does indeed exist in England, despite appearances, a more detailed conceptualisation of what such a system involves is currently lacking. Each one of the elements outlined above could be described as having its own system, although degrees of complexity (and the need to link across

different systems) will vary.   For instance, the Foresight report on tackling obesity views obesity as a complex system involving both biological and social factors (Government Office for Science 2007). An obesity system map was assembled and represents the most comprehensive 'whole systems' view of the determinants of obesity (see Diagram 4).   Obesity is not the product of biological changes but of changes in the external environment. It is what the report terms an 'obesogenic environment' that serves to expose and compound the 'biological vulnerability of human beings'.  In terms of how obesity might be tackled, the report makes it abundantly clear that 'the complexity and interrelationships of the obesity system… make a compelling case for the futility of isolated initiatives' (p.10).  Rather, what is required is 'a cross-cutting, comprehensive, long-term strategy that brings together multiple stakeholders' (ibid).   It will pose a major challenge not just for medicine and public health narrowly conceived but for 'governance and decision-making' (p.12).

Map 0

Full Generic Map
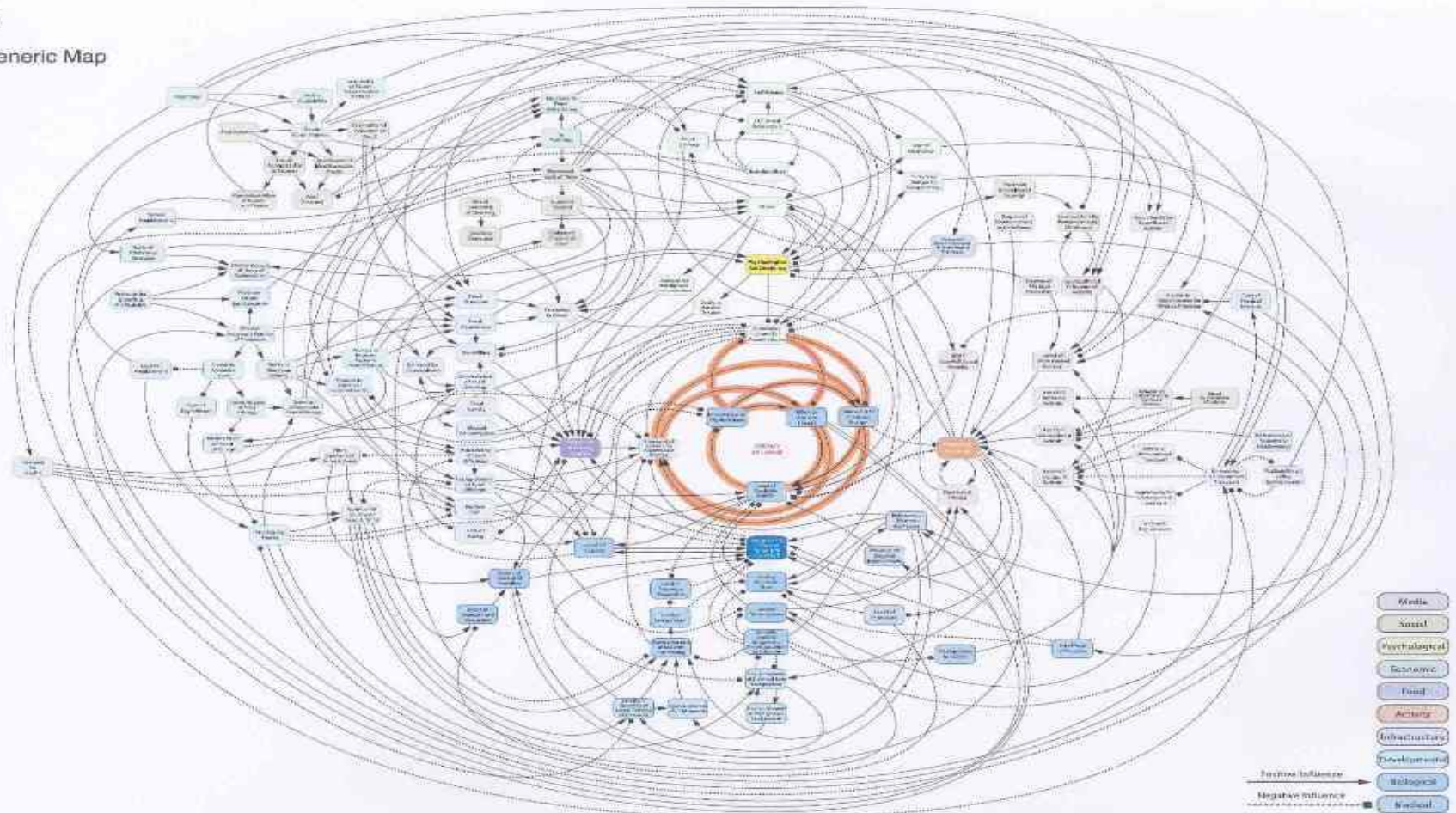
Although obesity is cited as an example of a complex public health issue, it is by no means unique. As the Foresight report notes, obesity has much in common with a number of other challenges facing public health. Indeed, the wider determinants of health, sometimes referred to as the 'causes of the causes', are essentially the same: 'The social, infrastructural and environmental factors that need to frame the planning and implementation of policies for obesity coincide with many other public health issues' (p.13). As the report also emphasises, many of the key public health challenges cannot be solved by exhortations for greater individual responsibility. Nor do solutions lie in short-term fragmented initiatives. These points are echoed in relation to the social determinants of health more generally in a recent report on the evidence base for tackling these determinants presented to the World Health Organization's Commission on the Social Determinants of Health (Kelly et al 2007).

In the light of such a critique of existing policy responses and institutions, it seems that current approaches to public health, combined with their failure to deliver, fall woefully short of the required response. While the list provided by the Department of Health above clearly suggests the public health system is multi-disciplinary and involves intersectoral partnerships, no detail is provided as to precisely who is involved in these arrangements and what role(s) they are expected to undertake. In an attempt to make sense of the wide range of activities which go to make up public health, the framework produced by the Faculty of Public Health to describe the public health function has been widely endorsed as a reasonable statement of what public health does and is about. The framework views public health as being made up of three overlapping domains:

- *Health protection:* embraces infectious diseases, chemicals and poisons, radiation, emergency response, environmental health hazards immunisation and vaccination
- *Health improvement:* embraces tackling health inequalities, education, housing, employment, family/community issues, lifestyles, surveillance and monitoring of specific diseases and risk factors, screening
- *Health service quality improvement:* embraces clinical governance, clinical effectiveness, evidence based medicine, efficiency, service planning, audit and evaluation.

A complex system of advisory bodies, arms length bodies, and shared responsibilities populates these domains, combined with an increasingly diverse mix of providers. The National Institute for Health and Clinical Excellence (NICE) is developing evidence based guidance for public health interventions; and the Healthcare Commission is monitoring core and developmental standards for public health through its Annual Health Check. However, various public health functions are dispersed across multiple organisations operating at different levels and principally embracing the NHS, local government and non-governmental organisations.

Health protection is regarded as a 'new concept that has gained popularity as an area of public health activity in the last decade' (Nicoll 2007). The function overlaps with environmental public health and is divided between the national Health Protection Agency, the NHS and local government. Health improvement is similarly dispersed across a range of agencies although with less focus around a single agency. The NHS is accorded the lead role for health improvement although it is recognised that

partnership working across the NHS and local government, including other stakeholders, is essential. There is also a major emphasis in this domain on issues around neighbourhood renewal and urban regeneration, and on area based initiatives. Finally, health service improvement is regarded as principally an NHS function led by the DPH in each organisation.

While this review is concerned with all three domains and their interaction, its primary focus is firmly on the second domain where debate over the nature of the public health function and the boundaries of formal (and informal) public health systems has been most intense. Reference is made to the other domains as and where appropriate. The origins of these three domains 'lie in the historic importance of the control of communicable disease, health education and the role of hospital and community services over the past 150 years' (Griffiths, Jewell and Donnelly 2005: 910). According to Griffiths, Jewell and Donnelly, conceptualising the breadth of public health within the framework of the three domains of practice is intended to make the management task more practicable. In respect of any public health problem, the domains can help to frame both the actions required and those who need to be engaged in constructing the public health response. They can also be employed to understand the skill mix needed by those delivering services. However, what the domains could be accused of failing to do is address what has been described as the philosophical lacuna in public health (Lewis 1986). Moreover, many leading figures in public health question whether splitting public health into three domains is helpful when problems may cut across the domains and require a mix of skills (for a selection of views on this point, see Faculty of Public Health newsletter, *ph.com*, on the public health future, September 2007). There is also a concern that the domains remain largely NHS focused with an inevitable concentration on downstream solutions. Although not unimportant, these solutions will be insufficient to meet the challenge set out by the Foresight report in respect of obesity. In the light of these difficulties, it may be that in future topic based specialisation will occur, with a consequent blurring of the three domains.

Defining the public health system in England, therefore, becomes quite a complex task, and one that is compounded by the absence of a coherent approach and of an explicit and agreed notion of such a system against which current activities can be assessed. This is reflected in key debates within public health, health promotion and general practice.

As noted earlier, there are clear resonances between the IOM approach and developments in the public health system in England. Health and wellbeing partnerships span health, local government, business and community organisations. However, as discussed later in this report, the public health infrastructure at both national and local levels remains weak and fragmented. The tensions outlined above (Section 2) have undermined a coherent and sustained approach and longer term public health priorities forever fall prey to immediate demands emanating from the health care system.

As a specific example of support for the notion of a public health system in England, the North West Region has developed the concept following a high level workshop to investigate and map the public health system in order to explore its implications at a

regional level (Ellis 2005). The workshop report identified a number of issues which needed to be addressed to achieve a public health system that is 'fit for purpose':

- The overall public health system needs to be mapped and described: which organisations are part of it, and what each is required to contribute to improve and protect health
- An organisation's contribution to public health should not be optional and it should be held accountable for its delivery
- Organisational boundaries can be an obstacle to delivery – all relevant organisations should have a duty of partnership and recognise the public health system will become network driven, with people contributing from all levels; the workforce must be liberated from its 'silos' to enable cross-skilling and provide public health input where the people who need it are located
- To overcome the fragmentation in public health governance between district and regional levels and across different agencies, a more coherent and robust accountability structure is required
- The subsidiarity principle should apply, namely, that the delivery of public health goals should be undertaken locally wherever possible, and be the responsibility of a jointly appointed DPH, accountable to the local authority and NHS; higher tier, eg regional, responsibility should be reserved for rare incidents and scarce expertise and for developing strategic frameworks informed by those responsible for local delivery
- The rate and number of innovative schemes is unsustainable, especially when they are subject to short-term funding and fail to get mainstreamed, even when demonstrably effective; more work needs to be put into (a) mainstreaming innovations that work by using real-time research and development that is both relevant and timely in meeting public health goals, and (b) acting on the evidence where appropriate
- Greater health literacy is called for, as recommended by Wanless; people need to be engaged in their health and understand what contributes to, and damages, it in order to act as a form of advocacy and help foster the creation of 'tipping points' whereby pressure is put on government to act in the interests of the public good (Gladwell 2001)
- Employers are a key platform for strengthening health literacy among the workforce and this is in keeping with the healthy settings approach advocated in the 1999 health strategy; as 49 per cent of the North West GDP is spent in the public sector this should be an 'engine' for action on public health
- Intelligence needs analysing at a higher level of aggregation but results should be accessible locally; all parts of a public health delivery system should be obliged to collect quality information so it can be analysed and acted upon; vertical integration of the public health system is needed in respect of shared information systems, shared policy objectives at each level, and high quality R&D.

Another attempt to embed a public health ethos across a wide range of sectors is evident in a study carried out in England for the King's Fund (Hunter and Marks 2005). It promotes a notion of 'public health governance', placing significant emphasis on the 'stewardship' role of government, and the development of 'proactive public health organisations'. Drawing parallels with corporate and clinical governance, Hunter and Marks suggest 'public health governance' ought to embrace

four dimensions: professional performance, resource use, risk management and public satisfaction with interventions/services. Furthermore, 'public health governance must be rigorous in its application, organisation-wide in its emphasis, accountable in its delivery, developmental in its thrust, and positive in its impact.' (Hunter and Marks 2005: 43). In Hunter and Marks' conception, the development of public health governance is closely tied to the notion of 'proactive public health organisations'.

Such an organisation

- *'Recognises that improving the public's health and reducing health inequalities is a proactive process – not a reactive one that deals with the consequences of ill health*
- *Recognises that this process goes beyond the NHS or any other, single actor*
- *Integrates policy streams and resource flows, so that suitable proactive public health policies can be crafted and implemented*
- *Makes public health part of everybody's job description*
- *'Completes the loop' by building public health needs into its monitoring and appraisal processes, so that successes and failures can be identified and adapted'* (Hunter and Marks 2005: 44).

Rather than denoting the creation of a new organisation, and similar to the notions of a 'public health system' and 'capacity building', the idea of proactive public health organisations involves embedding an ethos of public health into mainstream thinking so that all organisations of relevance to the public's health become 'proactive public health organisations'. Creating such organisations will require a commitment to change as well as the appropriate investment of resources.

While the above approaches each take a different direction in promoting public health, they have in common a commitment to developing a widespread culture of public health improvement across a range of sectors that regard themselves as part of a public health system and whose activities are aligned to achieve a common purpose.

In our view, and given the continuing problems over defining what public health is and who should do it, it would perhaps make more sense to have a clear understanding of the potential constituents of a public health system so that when issues arise in public health, appropriate parts of that system can be mobilised. This might include policy advocacy as well as issues around governance and delivery. Such a pragmatic way forward might avoid the interminable and inconclusive debates over who practices public health and what specialist training they might need. Instead, it would not matter where practitioners and skill sets were located as long as there was an understanding that they were embraced by the notion of a public health system and shared its underlying values.

## 4. Public Health After 1974: the End of the Beginning or Beginning of the End?

The development of public health policy and practice since the 1970s has been marked by two major inter-related tensions: first, whether public health is a largely

medical domain or whether, because of the wider determinants of health, it is multi-disciplinary; and, second, where the public health workforce, whoever that may include, is or should be located. These tensions have resulted in endless debates about whether the NHS or local government should lead on public health and who is best equipped for the role. In our brief account of developments since 1974 there is perhaps an inevitable focus on the NHS and public health medicine because that is where, for better or worse, much of the attention has centred in terms of policy and practice, and also where much of the power struggle around professional and practice issues has been played out. But developments in local government through neighbourhood renewal and regeneration initiatives and through broad partnerships for health and well-being are now playing an increasingly important role in framing a public health agenda, and we have sought to capture these (Stewart 2007).

In relation to the first tension listed above, few would now argue that public health is not a multi-disciplinary effort (McPherson and Fox 1997; Evans and Knight (eds) 2006) and yet, despite this, public health in the last quarter of the 20th century remained plagued by distinctions between 'medical' and 'non-medical' members of the workforce (Wills and Woodhead 2004). The various moves towards creating a multi-disciplinary public health workforce have encountered a range of difficulties (see further below). A key part of the problem, claim Wills and Woodhead (2004), is a failure to focus on the shared values that bind such a broad and diverse collection of individuals together, and a resulting absence of collective identity.

In terms of the second tension, the locus of responsibility for public health action (and, therefore, the main location for the public health workforce) has been a hotly contested issue since 1974. Holland and Stewart (1998) outline three potential options for the location and organisation of public health:

- local government
- independent national body
- health service (NHS).

In the period between 1974 and 2006, there was a shift from local government to the NHS (although this did not affect all services of importance to health, notably environmental health which remained with local government), followed by a long and chequered process of attempting to ensure that responsibility for public health was shared between agencies and across locations, with a truly multi-disciplinary workforce being the aim.

Each model comprises a mix of potential benefits and problems, as Holland and Stewart (1998) explain. On the one hand, for example, the location of public health within local government can lead to a weakening of essential links between those who have access to health information and specialist health knowledge and those with the main responsibility for the public health function. On the other hand, the location of public health within the health service limits the influence that practitioners are likely to be able to exert over policies relating to wider determinants of health, such as housing and education. Furthermore, the location of public health specialists within the NHS has often resulted in their role being concerned rather more with health service planning than with other aspects of public health. Finally, having an independent national body for public health may suppress local innovations and may,

furthermore, face the possibility of closure/reorganisation if its decisions do not fit with the wider political context. The experience of New Zealand's Public Health Commission is salutary in this respect. Established in 1993, it was disbanded two years later with its functions reintegrated into the Ministry of Health and regional health authorities. The reasons were a combination of 'opposing industry (tobacco and alcohol) pressure, bureaucratic rivalry and a ministerial preference for closer proximity of the public health function' (Davis and Lin 2004: 200). Recent Welsh experience in respect of a national organisation for public health is closer to the former New Zealand public health commission model but the arrangements have not been operating long enough to reach a considered view as to their effectiveness or not. In any case, one of the first moves of the recently appointed Chief Medical Officer for Wales was the announcement of a review of the public health system the results of which will almost certainly lead to changes in current arrangements.

Despite claims to the contrary, and as we demonstrate later in this section, there has never been a 'golden age' in public health although there is a widespread perception that somehow things were better pre-1974 when public health was a local government responsibility led by Medical Officers of Health (MOsH) who were often key figures in their communities. As Lewis (1986) notes, while MOsH who were separate from the NHS could in theory consider the health of the entire community rather than simply concern themselves with service considerations, in fact they rarely did so in practice. As she goes on to say: 'it cannot be argued that the transition to community medicine was achieved at the expense of an enormously vigorous public health system' (ibid: 163). However, MOsH did have formal authority to investigate any factor with a bearing on health and had security of tenure which meant that they could criticise employing authorities with impunity (Editorial 1981). And there were examples of inspired leadership where effective MOsH displayed networking skills and personal diplomacy of relevance in contemporary public health especially in the context of partnership working (Gorsky 2007). Such leadership also involved facing down vested interests thereby combining social conscience with scientific intent. In the end, the failure of MOsH had much to do with the orientation of the NHS towards the hospital service and the attenuation of local authority powers which served to marginalise public health, demoralise the profession and deprive it of resources. As Gorsky notes, 'soon after 1974, fears that something had been lost with the MOH began to be articulated' (ibid: 471).

After 1974, when local government was stripped of many of its public health responsibilities, the view has taken root in many quarters that the public health profession was hi-jacked by a managerialist agenda focused on health care services and became part of an essentially NHS agenda which was more concerned about downstream secondary and largely hospital-based care rather than upstream primary prevention in the community. This transition meant that the MOH and the public health department disappeared with the majority of MOsH becoming community physicians appointed by the NHS. As noted above, environmental health remained with local government under directors of environmental health. It has been argued that post-1974 insufficient attention was given to local social and environmental determinants of health by specialists in community medicine. While many in public health were concerned about the downstream focus of much of their work within the NHS, others accepted it as the price to be paid for securing a seat at the top table when it came to deciding how resources should be allocated and priorities agreed.

Nevertheless, as Webster points out, community medicine failed to achieve the status intended by its architects and recruitment declined (Webster 2002).

In fact, concerns about the public health profession and practice go far beyond its optimal location and certainly predate 1974 although have come to a head since then. In her account of public health since 1919, Lewis (ibid: 3) claims that the most important failure of public health 'was its lack of a firm philosophy to guide it in approaching health problems'. Such a state of affairs has continued to the present day with the idea of public health remaining indistinct and alternating between a focus on personal prevention on the one hand and a focus on structural determinants enshrined in the notion of healthy public policy on the other. Moreover, public health professionals throughout this period have continued to occupy a subservient position within the medical profession. Moves in recent years to open up public health to those who are not clinically qualified have done little so far to dent this deep-seated power imbalance. Perhaps one reason for this continuing imbalance is what Lewis refers to as the failure on the part of public health practitioners to recognise the need for a coherent philosophy. She claims that this vacuum was the principal reason for some observers suggesting that public health resembled a 'ragbag of activities' unconnected by any guiding principles.

It might be argued that it is not so much the absence of a unifying theory that is the problem but the existence of several competing theories each with its respective advocates and lobbies both inside and outside the public health system. Whichever is in the ascendant depends on the prevailing wider political and ideological context at the time.

For whatever reason, the absence of a clearly articulated and accepted philosophy and set of values underpinning the public health function remains a concern in establishing and sustaining a vigorous public health system. It may also account for the continuing fragility and vulnerability of the public health profession which has been a consistent feature throughout its development but especially since 1974 when the focus and direction of public health has been inextricably tied up with the NHS and its bias towards, and preoccupation with, acute care and hospital beds. Webster (2002) claims that community medicine's limited success was reflected in the failure to reshape the health service in favour of health prevention and promotion. Instead, it presided over the increasing fragmentation of public health responsibilities and activities. Berridge (1999) also notes the unease among community physicians about their loss of contact with the local community and their increasing role in managing health services rather than analysing broader health problems. Lewis goes further and suggests:

*The position of community physicians was subject to serious conflicts in terms both of their relationship with other members of the medical profession, and the nature of their primary responsibility, whether for the management of health services or for the analysis of health problems and health needs (Lewis 1986: 135).*

She concludes that the role of community physicians was very much determined by their place in the new NHS.

Some of the above observations concerning the state of public health during the 20<sup>th</sup> century in England are echoed in Julio Frenk's important essay on the international crisis in public health published some years later in 1992. He wrote:

*...public health has historically been one of the vital forces leading to reflection on, and collective action for, health and well-being. The widespread impression exists today, however, that this leading role has been weakening and that public health is experiencing a severe identity crisis, as well as a crisis of organisation and accomplishment* (Frenk 1992: 68).

Given these observations on the state of public health over the period with which we are concerned, it seems desirable to attempt to clarify what public health is, with particular reference to England. Not only does this remain a problematic and unresolved issue, but it is fundamental to understanding the somewhat precarious journey public health has been on in recent decades. Moreover, the absence of consensus about what public health is represents an ongoing impediment to establishing what an appropriate public health system fit to tackle contemporary public health problems might look like. Whatever such a system might comprise and set out to achieve, it surely needs to be governed by a coherent philosophy and clear sense of purpose. Without these it becomes less clear what sort of workforce is required and with which skills and competencies it needs to be equipped.

## 4.1 What is public health?

Over the years intense argument has taken place over how public health should be defined: whether it is medical specialty, whether it is multi-disciplinary, or whether it is just a specialty to which many disciplines contribute. As a former President of the Association of Directors of Public Health, told the House of Commons Health Committee at the time of its 2001 inquiry into public health,

*one of the difficulties of the term 'public health' is that it means different things to different people...Public health can span everything...The difficulty with that is that when something like public health becomes everybody's business, what is distinctive about those people who claim to practice public health and what is the added value that they actually bring to that?* (Health Committee 2001).

Definitions of public health abound, varying between times and contexts (Hunter 2003; Hamlin 2002). Lewis (1986) has suggested that for the first three-quarters of the 20th century, public health was characterised by its failure to define a clear and united identity, a trend which Wills and Woodhead (2004) claim has continued into the 21<sup>st</sup> century. That said, there are commonalities among the majority of definitions. Public health is usually thought to concern the health of populations (rather than individuals) and, as such, often makes reference to wider determinants of health and a general sense of common interest (Beaglehole et al 2004). Furthermore, in contrast with health care services, public health is concerned with long-term health issues and trends.

Lewis's account of the development of the public health profession since the end of World War I shows that public health in 20th century Britain has gone through a number of different phases. She suggests that behind these developments there existed an ongoing tension between the widespread and multi-disciplinary nature of the aims

of public health, on the one hand, and the desire to develop a recognisable public health specialist discipline within medicine on the other. Not only has this tension resulted in an ever-changing terminology to describe the public health function, it has also led to inconclusive debates about the preferred location for public health specialists and the nature of the role of the public health workforce (see next sub-section). Moreover, the philosophy of the UK government in the 1980s, which was hostile to the notion of government intervention to address inequalities in health ('variations in health' being the preferred and less emotive term), contributed to a fragmented and partial formal public health system which reinforced the emphasis on individual responsibility.

Disagreements about how to define public health in the 1980s were not confined to the UK. In the USA, the Institute of Medicine (IOM) published a report which stated that

*public health, as a profession, as a governmental activity, as a commitment of society is neither clearly defined, adequately supported, nor fully understood* (Institute of Medicine 1988: v).

In the UK, in the same year as the IOM Report, an official inquiry into the public health function underlined a move away from use of the term 'community medicine' and back to 'public health', outlining the following definition of the public health function: 'the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society' (Acheson 1988). The definition has enjoyed wide acclaim both in the UK and internationally. It formed the basis of Wanless's definition of public health in his government-commissioned review of the state of public health policy and practice in England (Wanless 2004). His emphasis was on viewing 'the organised efforts of society' in the widest sense to include not only government, public and private sector organisations, and communities, 'but also the aggregate efforts of individuals in respect of their and their families' health status' (Wanless 2004: 27). Extending Acheson's original definition, he therefore proposed what he regarded as a more appropriate definition in keeping with contemporary thinking and government public policy:

*The science and art of preventing disease, prolonging life and promoting health through the organised efforts* **and informed choices** *of society,* **organisations, public and private, communities and individuals** [new words in bold].

While some commentators believe Acheson's definition to be clear and acceptable, arguing that those involved in public health need to become more focused and united around this conceptualisation, others are calling for renewed reflection on what public health is, and what values tie it together (Beaglehole et al 2004; Wills and Woodhead 2004).

Following the election of a Labour government in 1997, a review of the public health function, was undertaken by the then CMO for England, Kenneth Calman. The final report was published four years later by Calman's successor, Liam Donaldson Department of Health 2001c). It cites the Acheson review which describes public health as:

*... efforts to preserve health by minimising and where possible removing injurious environmental, social and behavioural influences, but also the provision of effective and efficient services to restore the sick to health, and where this is impracticable, to reduce to a minimum suffering, disability and dependence.* (Department of Health 2001c, quoted on p.5).

The report also lists the Ottawa Charter's five key areas for action (World Health Organisation 1986):

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skill
- re-orienting health services.

It claims that most definitions of public health share important elements:

*All these definitions reflect the fact that health and wellbeing is dependent on a range of social, economic, environmental, biological and service factors. It follows that a range of agencies and organisations in all sectors of society can improve health by their actions, even if indirectly* (Department of Health 2001c: 6).

While having much in common, the various definitions also contain a number of deep-seated tensions, the most significant of which is probably the tension between a broad, multi-disciplinary conception of public health on the one hand, and one which sees public health as part of a medical tradition on the other. There are also tensions between a public health function that focuses on prevention, and one which is involved in planning and managing health provision for existing health problems (Berridge 2000). Adherence to the three domains of public health developed by the Faculty (listed in Section 3) has tended to reinforce and compound these tensions by simply bundling all of them into the remit and job description of public health practitioners.

The lack of clarity over the public health function persists with, for example, Crowley and Hunter (2005: 265) claiming that public health is 'being interpreted through the narrow prism of ill health and disease'. Elsewhere, Hunter (2003: 101) argues that the term 'public health' is itself a handicap, 'since it is not recognised outside the NHS and is imbued with medical overtones' – unlike, for example, the terms 'health and well-being' largely favoured by local authorities.

As described in Section 3, a broad definition of public health, embracing social and ecological approaches, and most recently articulated in the Foresight report on obesity, echoes the principles of primary health care spelled out in the Declaration of Alma Ata in 1978. These reflected a move away from narrow professionally-led conceptions of primary health care towards a more participative and multi-sectoral approach. Recognised as fundamental to population health and therefore to a public health system, the public health aspects of primary care in the UK have been only partially exploited. Revisiting Alma Ata 28 years later, Green, Ross and Mirzoev (2007) conclude that while it remains a useful framework for assessing health systems, in the English context there remains a gap between policy and practice.

Furthermore, they view the introduction of the 'choice' agenda and a market model for health as potential distractions from the purpose of achieving health and believe they succeed only in widening health inequalities between social groups.

A more long-standing problem in primary care in England has been its identification as synonymous with GP practice. This has given rise to problems between many GPs and public health practitioners over the years. The medical model underpinning many definitions of primary care (and public health for that matter) has inhibited the development of community perspectives on health (Taylor, Peckham and Turton 1998). The NHS Act of 1946 did not include prevention in the contract for GPs, a situation which continued until the late 1970s when the Royal College of GPs took up the cause of prevention and 'anticipatory care'. Lewis (1987) points out, for example, that GPs were suspicious of the aims by MOsH in the 1960s to build health centres which would allow them to coordinate community based health services. She quotes Titmuss, who asked whether there would be a place for the MOH and the public health department if GPs were to become community doctors. Despite interest in anticipatory care, this largely meant individually oriented, *clinical* anticipatory care. There has been a steady stream of influential GPs who have argued for primary care to exploit its public health dimension (Pickles 1929, Fry 1968, Tudor Hart 1988) and to demonstrate a commitment to the health of the local population. There were arguments that the public health content of primary care should be explicitly recognised and Mant and Anderson (1985) argued for the eventual integration of community medicine and general practice. They point out the ironies of 'the divisions in the structure of the health service which have led to a community based medicine specialty without access to the community and a primary care-led system without responsibility for the community's health'. Others also argued that public health had to recognise both approaches, even though they were organised and funded in different ways (Stone 1987).

The location of directorates of public health in PCTs and the formation of public health networks to cross organisational boundaries could be seen as encouraging this development. Moreover, the new GP contract, implemented in 2004, allows for payment to be tailored to specific services and it is intended further to develop its health promotion aspects. However, as Peckham and Exworthy (2003) note, primary care in the UK has been primarily focused on general practice working within a medical model of health. The social model on which public health draws has generally been the exception in primary care. Popay, in her evidence to the Health Committee's inquiry into public health, referred to the 'awesome' expectations laid upon primary care to deliver the public health agenda noting the absence of evidence to suggest that GPs either 'have the capacity or the inclination' to move upstream (Health Committee 2001). The equation of primary medical care with primary health care has been problematic throughout the history of primary care as, indeed, it has throughout the history of public health medicine.

The extensive discussions and debates about the public health function recently led the CMO for England to complain in his 2005 annual report of 'constant 'navel gazing' [which] has ultimately eroded the focus and consistency of purpose of the public health function' (Department of Health 2006). Yet the problem of defining public health is more than a linguistic conundrum – it goes to the heart of what public

health as a system is intended to do and with what means. As Mallinson and colleagues put it:

*The symbolic nature of language is part of the mechanism people use to position themselves as an 'insider' or 'outsider' in a particular interest field* (Mallinson, Popay and Kowarzik 2006).

For their part, Crowley and Hunter (2005: 265) argue that

*greater clarity and focus is required if public health is to deliver [...], especially in respect of health improvement that demands skills from a range of agencies outside the NHS and located within communities.*

Yet, at the same time, agreeing on a definition for a subject that is so broad is inevitably problematic and may not be possible. As Garrett (2002) surmises, whilst there appears to be some level of consensus around the nature of public health, at a broad theoretical level, as being something which focuses on the health of the population and which benefits everyone, there is little consensus on how to translate broad policy statements into effective action.

The reasons for this lack of consensus lie in large part in fundamental disagreements over the respective roles of the individual versus the collective or State (Hunter 2005; Jochelson 2006). These tensions have re-emerged in recent policy debates about the 'nanny state', especially in relation to lifestyle factors such as alcohol use, nutrition and exercise. WHO argues for the stewardship function of government to be strengthened on the grounds that protection of the public's health is a fundamental responsibility of government (Travis et al 2002), an approach echoed in a report on ethical issues in public health from the Nuffield Council on Bioethics (2007). According to some analysts, if there are only some things that government can do to promote health then such interventions should not be rejected as paternalistic state interference but should be regarded as enlightened government acting for the greater good.  The decision to ban smoking in public places in Ireland, which has more recently been adopted across the UK (starting with Scotland in March 2006) could be viewed as an example of this kind of intervention.

Some of these difficulties and dilemmas surrounding definitions of public health and the 'public health system' are brought to the fore in the next sub-section, which examines the nature of the public health workforce in England.

**4.2 Who does public health?**
Difficulties in defining or conceptualising the 'public health workforce' in terms of all the factors that could potentially influence health are closely linked with the various definitions of public health reviewed in the preceding section and the three domains articulated by the Faculty of Public Health (2007)  – health protection, health improvement, and health service quality improvement.  It is perhaps unsurprising, therefore, that there have been significant changes and developments around the notion of the public health workforce in England since 1974 and that these have invariably reflected the shifting policy emphases on individual versus collective approaches to public health.

Our story begins with the demise of the MOsH and the shift of much of their work to the NHS. Support for change grew in 1970 and 1972 when social work and environmental health were respectively each separated from the MOsH's responsibilities, thereby weakening their influence. Also in 1972, following a recommendation of the Todd Report, the Faculty for Community Medicine was established, with membership restricted to registered medical practitioners. It is in this context that, at the time of the 1974 NHS reorganisation, public health changed its name to 'community medicine' and was integrated into the NHS.

The role of 'community physicians', as originally conceived of by Morris (1969), revolved around a concern with epidemiology and population health. However, as we saw in the last section, and as a recent witness seminar in London testifies (Berridge, Christie and Tansey 2006), there was a great deal of confusion as to what the role of community physicians involved. A survey of community physicians (with service roles) in English health authorities undertaken by the King's Fund Institute demonstrated that considerable uncertainty about lines of accountability existed, and, furthermore, there was evidence of gaps in training and skills, especially around environmental health and communicable disease control, and suggestions of tensions/problems around the advisory role of community physicians to local authorities (Harvey and Judge 1988). Another survey of community physicians in England showed that 60 per cent of their time was taken up with administration and only nine per cent with preventive medicine (Donaldson and Hall 1979). Stewart (1987: 734) sums up some of the frustrations of this period:

*[The role of specialists in community medicine was] never clearly defined or understood even within the specialty and lacking in executive and infrastructural clout, was further eroded by subsequent reorganisations. In many health authorities, the specialist in community medicine now operates alone, without a department, with equivocal status, and a self-made or uncertain range of duties which are often seen to be marginal or trivial even when there is room for individual initiative.*

Stewart (1987: 736) goes on to claim that the range of job titles and responsibilities within the field of 'community medicine' were unclear, arguing: 'Designations are useless unless they describe the job in a manner understandable to medical and non-medical colleagues and to the public.' It is a view that remains alive in discussions around public health. For example, McPherson et al (1999: 4) claim that public health has suffered from being 'too close to health care and too far from health' by which they mean that public health has been 'largely administered from within the NHS and the focus of resources has tended to be on individual patient care at the expense of public health activities targeted at the wider population' (ibid). With health services being demand led and public health policy-led, they conclude that the former will continue to attract the lion's share of resources 'whatever the rational merits of the situation' (ibid: 26). The view is also echoed by many giving evidence to the Health Committee's public health inquiry in 2001 (Health Committee 2001).

As Hunter (2003) notes, community medicine appears to have encountered two major problems in trying to fulfil Morris' original vision: first, their location within the health service separated community physicians from many of the relevant factors and agencies (eg housing, employment and environment); second, community physicians' concern with collective population health often brought them into conflict with the

individualised focus of other medical practitioners. Indeed, as the discussions at two recent witness seminars concerned with public health history both indicate (Berridge, Christie and Tansey 2004; Evans and Knight 2006), the community physicians of the 1980s were not accorded the same respect as consultants in other medical specialities, which led to tensions between the Faculty for Public Health and the British Medical Association. The fact that there was (and remains) no trade union specifically for public health workers in England may have further hindered progress towards a multi-disciplinary workforce.

## 4.3 The emergence of the 'new' public health

From the end of the 1970s, a sense of growing exasperation with the neglect of public health and prevention was instrumental in fostering a broad, and some would say political, movement, concerned to develop what came to be known as 'the new public health' which drew on the spirit and example of the early pioneers in public health but in the context of the new health challenges (Ashton and Seymour 1988; Unit for the Study of Health Policy 1979).  Webster (1992) argues that, 'as in the 1930s, much of the impetus for the New Public Health has emerged from outside the ranks of public health organisations, initiatives in other western nations, or lay and scientific pressure groups' (Webster 1992).

The movement was also underpinned by an emerging body of literature which underlined the interplay between health and social and environmental factors and emphasised the role of public policy, intersectoral collaboration, and community action. A key influence was the publication of a Canadian policy document called *A New Perspective on the Health of Canadians* (Lalonde 1974), which quickly received international attention for its arguments concerning the need to shift the focus of health policy from healthcare to the prevention of ill-health.

The development of the 'New Public Health movement' in the UK in the mid-1980s was partly aimed at re-creating the link between environmental health and public health medicine which had become severed by the 1974 NHS reorganisation and the move into it of public health medicine. Ashton and Seymour's book with its title, *The New Public Health,* quickly became a landmark. The authors saw 'health promotion as the means to health for all', by which they meant 'a process of enabling people to increase control over and improve their health' (Ashton and Seymour 1988: 25). The impact of the environment, together with a wide range of social factors, on health was regarded as supremely important by public health organisations like the Public Health Alliance whose Charter for Public Health (1987) included environmental change in respect of housing, food and work (now reflected in the work of the UKPHA with its commitment to promoting sustainable development and challenging a wide range of anti health forces (UKPHA 2007)). Environmental protection was also perceived to be critical to public health and concern was expressed that, with the loss of the Medical Officer of Health, environmental protection measures had been downgraded in importance.

As has been well-documented, concerns to address inequalities in health and recognise the role played by poverty and social conditions in determining health status were largely ignored by the Thatcher administration (Berridge and Blume 2003).  The Black Report (Department of Health and Social Security 1980) argued that social inequalities in health were largely the result of material-structuralist factors, but its

findings had little impact on policy and the report was effectively shelved, an outcome not helped by being set up by a Labour government but reporting to a Conservative one. Arguments for a multidisciplinary approach to public health and health promotion in the context of a contemporary public health (Unit for the Study of Health Policy 1979) and the establishment of consultant level posts from backgrounds other than medicine did not surface or become reality until many years later.

It is in this context that, in 1987, after producing a series of rather critical reports, the semi-independent Health Education Council (which had replaced the Central Council for Health Education in 1967) was replaced by the markedly less independent special health authority, the Health Education Authority (for the context to this change see Sutherland 1987). In time, health promotion became less concerned with a social ecological approach to public health and retreated back to a focus on individual lifestyles and behaviour change.

Despite the difficulties arising for public health from the national political context in England during the 1980s, it was a fertile period of progressive advances for public health at regional and international levels, with links between the two, as a recent witness seminar on public health in England recounts (Evans and Knight 2006). The World Health Organisation (WHO) conference at Alma Ata in 1978 (World Health Organisation 1978) was followed by the WHO's Health for All by the Year 2000 policy (World Health Organisation 1981) and the Ottawa Charter for Health Promotion which followed in 1986. The Ottawa Charter is often considered to have been ahead of its time with its full importance and potential yet to be fully recognised and realised (Hills and McQueen (eds) 2007). These seminal reports emphasised the importance of healthy public policy, community action, and supportive environments as well as personal skills in making healthy choices. These approaches were increasingly adopted by health promotion officers and others who at that time presented a radical and alternative approach to the public health establishment (Berridge, Christie and Tansey 2004). There was a link between the emerging 'new public health' with its interest in participation, and the community health movement with its ideas of empowerment, of informed action, capacity building, and critical social analysis. Community health needs assessment began to focus on equity and socio environmental issues, and moved towards a more participatory approach with an emphasis on understanding, as opposed to describing, needs. Despite the Thatcher government's uncomfortable stance towards health promotion, particular English regions were highly focused on developing public health during the 1980s. Liverpool, which produced one of England's first regional reports on public health (Ashton 1984), was a notable example. In this context, international links between various regional public health projects developed, such as links between Liverpool and North Karelia in Finland (Berridge, Christie and Tansey 2004).

The *Healthy Cities* project, first established by WHO in 1985, was viewed as a test bed for *Health for All*. It was thought that strategies for building supportive environments, combating health inequalities, and developing healthy public policies could be created and evaluated at city level so that real change could take place. The *Healthy Cities* initiative was probably more successful as a concept than as practical reality especially since the freedoms enjoyed by local authorities in the UK were limited. But *Healthy Cities* projects did endeavour to develop intersectoral

collaboration between local authorities, health services, voluntary agencies and the private sector.

Under the Thatcher government, a series of organisational reforms in the NHS also affected those involved in public health (see Appendix 1 for further details of the changing structures). First, in 1980-82, there was a reorganisation from area health authorities to district health authorities, which was later followed by the gradual introduction of the internal-market to the NHS between 1989 and 1991. For the public health workforce, the introduction of the internal market meant new opportunities for some people (associated with a renewed interest in population health resulting from the commissioning role of some parts of the NHS) but severe marginalisation for others, especially those working in health promotion (Evans and Knight 2006). Organisations such as the Public Health Alliance (established in 1987) emerged as various individuals and networks attempted to keep the community development and health promotion aspects of public health going. While they did important work, they largely remained overshadowed by the continuing pull of the NHS and acute care sector neither of which was primarily concerned with prevention rather than treatment.

During this period, various outbreaks of diseases called attention to the necessity of a public health strategy in England. As well as the emergence of new communicable diseases, such as HIV/AIDS, there was also a series of high profile food health scares, including salmonella and BSE/CJD. The lack of clarity of workforce responsibilities following the reforms in the early 1980s, along with a shift towards a focus on chronic disease, were seen as contributory factors in several major communicable disease outbreaks later that decade, including the Stanley Royd Hospital outbreak of salmonellosis (Department of Health and Social Security 1986). Eventually, the various crises in 'community medicine' and 'public health' led to an official inquiry into the public health function in England. The critical nature of the evidence presented to this Inquiry underlines the extent to which dissatisfaction had grown. For example, the Department of Community Health at the London School of Hygiene and Tropical Medicine presented evidence which stated:

*Achievement of the fundamental tasks of community medicine is often frustrated. This is for a number of reasons including the short-term perspective of management in the NHS; the lack of non-medical members in community medicine teams; a shortage of support staff and facilities; the underdevelopment of the necessary tools for evaluating interventions; and inadequate continuing education facilities (Department of Community Health* (LSHTM unpublished).

The LSHTM's evidence also contends that community medicine suffered from a lack of sufficient knowledge and skills to carry out fundamental tasks, and experienced some antagonism from medically qualified staff towards the advent of multi-disciplinary teams. It further notes concern with the recruitment of doctors to community medicine: 'It is our contention that a major factor that has deterred potential recruits has been the lack of a clear image of the role and tasks involved.' (ibid: 11) Other evidence submitted to the Inquiry included a report from The Institution of Environmental Health Officers (unpublished) which claimed that local authorities may be a more appropriate location for the public health function than

health authorities. A common thread throughout the various submissions was the confusion surrounding the role and function of community physicians.

The resulting publication of Acheson's (1988) inquiry report outlined the need for a multi-disciplinary approach, whilst simultaneously reinforcing the assumption that public health should be led by medical professionals (with other professions playing no more than a supportive role). This report highlighted a shortage in consultants in health protection and recommended an initial workforce target of 15.8 specialists per million of the population. It was on the recommendation of this report that community medicine was renamed public health medicine. The report endorsed the WHO's *Health for All* strategy but its recommendations were criticised as 'over-influenced by the self interests of community physicians and environmental health officers' ignoring the role of the public and of the voluntary sector (Ashton 1988).

In the structure that emerged, although Directors of Public Health were supported by multi-disciplinary teams, there were significant tensions in terms of the inequalities of opportunities for non-medical staff working in this system, which led some of those involved to set up their own ad hoc networks (Evans and Knight 2006). However, these networks did not have professional status and, furthermore, the career structures for non-medical public health staff were extremely limited, with existing training and career development pathways focusing exclusively on those who were medically qualified. The extent of the increasing frustration amongst non-medically qualified staff at the lack of career prospects open to them is vividly apparent in the discussions at a recent witness seminar on the origins and development of multi-disciplinary public health in the UK (Evans and Knight 2006).

Throughout the period under review, the public health profession remained equated with public health medicine, with other relevant groups often being defined by the description 'non-medical' (Evans 2003). However, in 1991, the publication of *The Nation's Health* (Jacobson, Smith and Whitehead 1991) underlined the growing acceptance in policy terms that doctors could not undertake the public health agenda alone. With growing pressure on public health to become more multi-disciplinary, resulting from a combination of 'top down' and 'bottom up' pressures (Evans and Knight 2006), some university public health postgraduate courses began to attract non-medically qualified students. Following the establishment of the first multi-disciplinary Masters in Public Health at Cardiff University in 1990, the Masters in Public Health at the London School of Hygiene and Tropical Medicine became the first equivalent course in England to allow students from disciplines other than medicine to enrol in 1992. However, what the career opportunities for the newly qualified non-medical MPH graduates would be remained rather unclear. Although the Conservative government's *Health of the Nation* strategy (Secretary of State for Health 1992), the first of its kind in England, signalled a shift towards a public health focus it was almost solely concerned with health promotion, failing to acknowledge a need to tackle wider socio-economic and environmental determinants of health or seriously to deal with the dominance of healthcare services within the NHS (Department of Health 1998a; Hunter 2003).

As concern to highlight the multi-disciplinary nature of public health grew, a postal survey of public health professionals in 1994 identified over 1,000 people from non-medical backgrounds working in public health in the UK (Somervaille and Griffiths

1995). This developed into a working group to explore the issue further and was followed by a series of annual national seminars in Birmingham to explore career structures and training and accreditation requirements for multi-disciplinary roles in public health. In 1996, following one of the national conferences, concerned individuals established the Multi-disciplinary Public Health Forum (MDPHF), which aimed to promote the multi-disciplinary nature of public health and the associated training needs. In 1997 a joint statement of intent was issued by the MDPHF and the Royal Institute of Public Health that they would work together on the development of a framework for education, development and accreditation of multi-disciplinary public health professionals.

Following the election of a 'new Labour' government in 1997, one which had made commitments to tackling health inequalities and addressing the wider determinants of health in its election manifesto, a series of documents and debates highlighted the need to stop the fragmentation of public health and start developing its multi-disciplinary nature. Major initiatives at this time included the appointment of the first ever Minister for Public Health in 1997, the production of a new health strategy to replace *Health of the Nation*, an independent assessment of the impact of *Health of the Nation* (Department of Health 1998a), the establishment of an 'independent' inquiry into inequalities in health (chaired by Donald Acheson, a former Chief Medical Officer), and a review of the public health function led by the then Chief Medical Officer, Kenneth Calman. The Acheson Report (1998) made 39 recommendations for tackling health inequalities, the vast majority of which stretched far beyond the remit of the NHS. In the same year, an interim report of the *Chief Medical Officer's Project to Strengthen the Public Health Function* was published which expressed a commitment to multi-disciplinary working (Department of Health 1998b).

There then followed a more detailed commitment to developing multi-disciplinary public health, including a specific commitment to the creation of a new non-medical role of specialist in public health with the publication of a new health strategy, *Saving Lives: Our Healthier Nation* (Secretary of State for Health 1999). The white paper announced a number of initiatives to help develop a genuinely multi-disciplinary public health function. These included the production of a National Public Health Workforce Development Plan (which, although virtually completed, was never published), the completion of a Public Health Skills Audit, the creation of a Public Health Development Fund, and the establishment of the post of specialist in public health that, it claimed, would 'be of equivalent status in independent practice to medically qualified consultants in public health medicine and allow them to become directors of public health'. The same white paper also announced the establishment of the Health Development Agency (which would replace the Health Education Authority). Its mandate was to build and disseminate the evidence base for public health and to share knowledge and good practice.

The following year Alan Milburn, then Secretary of State for Health, gave the LSE Health annual lecture in which he called on those involved in public health to end 'lazy thinking and occupational protectionism' and 'take public health out of the ghetto' (Milburn 2000):

*[T]he time has come to take public health out of the ghetto. For too long the overarching label 'public health' has served to bundle together functions and occupations in a way that actually marginalizes them. [B]y a series of definitional sleights of hand the argument runs that the health of the population should be mainly improved by population-level health promotion and prevention, which in turn is best delivered—or at least overseen and managed— by medical consultants in public health. The time has come to abandon this lazy thinking and occupational protectionism.*

With a clearer acknowledgement of the role of wider determinants of health, the policy context was actively promoting notions of 'cross-sectoral', 'joined-up' and 'partnership' working, as well as placing significant emphasis on public involvement and accountability (eg Cabinet Office 1999). From a public health perspective, this resulted in a renewed focus on projects which sought to involve and empower communities, as well as a series of policy initiatives designed to promote partnership working, both within the NHS and between the NHS and other organisations. Various provisions to encourage joint working, including pooled budgets, were made in the 1999 Health Act. There were also a range of initiatives designed to promote partnership working, such as Health Action Zones and Health Improvement Programmes, plus a specific charge on PCTs to promote partnership working. The 2000 Local Government Act gave local authorities the power to promote social, economic and environmental well-being, placing a renewed emphasis on the role of public health in local government. Since then, support for jointly-appointed Directors of Public Health has emerged and their number has grown rapidly in recent years. All of this policy activity contributed to the notion that public health is indeed a multi-disciplinary enterprise which takes place in a range of contexts and at a variety of levels.

Another important departure in the post-1997 Labour government's approach to health has been a focus on targets and performance assessment. The focus has been extended to public health although arguably without the same degree of commitment or consistency (Hunter and Marks 2005). For example, the 1999 health strategy, *Saving Lives: Our Healthier Nation,* set out various health improvement targets in particular 'health problem areas' such as coronary heart disease and cancer. Since then, a series of changes and additions to targets of relevance to public health have been made, including the introduction of health inequalities targets focusing on life expectancy and infant mortality (Department of Health 2001a) as well as targets focusing on changing lifestyle behaviours, such as smoking. Public health is one of the seven domains (Department of Health 2004) for which core and developmental standards are monitored by the Healthcare Commission as part of its Annual Health Check. This includes assessments of conformity with public health guidance from NICE, and the developmental standards emphasise the importance of a whole systems approach. In addition to the notion that targets should act as drivers for action, some of the public service agreement targets have been used to promote collaboration between local government and the NHS through shared responsibility for outcomes. Moreover, Local Area Agreements (agreed across central government and a local area) now include a mandatory health inequalities indicator.

In the year after the first consultant-level specialist public health posts to be open to candidates from disciplines other than medicine were advertised by some health

authorities (2000), the Faculty of Public Health Medicine agreed that membership of the Faculty should be opened to candidates from disciplines other than medicine and dropped 'Medicine' from its title. Also in 2001, the final Report of the *Chief Medical Officer's Project to Strengthen the Public Health Function* was published (Department of Health 2001c), providing further support for the earlier policy statements' stance on the need for a multi-disciplinary approach to public health. The report identified three broad categories of people who comprise the public health workforce:

- *Specialists:* consultants in public health medicine and specialists in public health who work at a strategic or senior management level or at a senior level of scientific expertise to influence the health of the population or of a selected community
- *Public health practitioners:* those who spend a major part, or all, of their time in public health practice eg health visitors and school nurses.
- *Wider public health:* most people, including managers, who have a role in health improvement and reducing health inequalities although they may not recognise this, including: teachers, social workers, local business leaders, transport engineers, town planners, housing officers, regeneration managers and so on.

This categorisation, which does not suggest medical training is essential to individuals working in any of the three categories, remains central to Department of Health policy. The CMO's report also highlighted problems of under-capacity in the public health workforce and recommended significant government action to address the deficit:

*We need to make sure that the public health workforce across all sectors is skilled, staffed, and resourced to deal with the major task of delivering the Government's health strategy. An increase in capacity and capabilities must be achieved* (Department of Health 2001c: 24).

Importantly, the report suggests that a renewed drive to increase public health workforce capacity should be accompanied by moves to ensure the workforce becomes more multi-disciplinary in nature.

However, identifying exactly who or what comprises the public health workforce has created problems. In the late 1990s the PHSRU was tasked by the then Health Development Agency (HDA) to develop a plan for the public health workforce and it reported with its Public Health Workforce Development Plan in 2002 (Nevis Consulting Group, unpublished). Data on medically qualified specialists were easy to access but there was great difficulty in agreeing job descriptions for practitioners. Figures for the latter were gleaned from the NHS, local authorities and professional organisations.

The study concluded that the supply of practitioners was clearly insufficient. The HDA was subsequently tasked with developing regional workforce development plans. A number of studies have assessed the impact of the 2002 NHS reorganisation on public health. For example, one study found that medically qualified specialists were less skilled in community development, leadership and management (Barts and

the London/City University London 2003). Gaps in information analysis were common. Another study of the capacity and capabilities of the public health workforce pointed to:

- a lack of clarity surrounding the term 'specialist in public health and confusion regarding both the role of a specialist and the general public health function
- fragmentation of the workforce
- a loss of critical mass and the potential for professional isolation; key skills gaps including health protection, partnership working and leadership (Chapman, Shaw et al 2005).

Between 2001 and 2002, the Faculty of Public Health gradually opened up its public health examinations to non-medical candidates. Within the new primary care trusts, of which there were over 300 arising from the *Shifting the Balance of Power* (Department of Health 2001b), the first directors of public health from backgrounds other than medicine were appointed, and the Minister for Public Health at the time officially welcomed the fact that 'this generation of DsPH come from a variety of backgrounds – both medical and non-medical' (Blears 2002). She also welcomed new joint appointments of DsPH with local government suggesting such developments provided cause for optimism 'that multi-disciplinary public health will become a reality' (ibid). However, to allay any fears about substitution or marginalisation, she also stressed that doctors 'remain a crucial part of this new world'. Also at this time, and in keeping with this renewed emphasis on strengthening the wider public health workforce, the UK Voluntary Register for Public Health Specialists was established to help quality assure this new breed of non-clinical specialists (2003); the first trainee from a background other than medicine successfully completed their training through the Faculty of Public Health route (2005); and the Faculty had over 3000 members, one-third of whom were from backgrounds other than medicine (Evans and Knight 2006).

Many of those involved in public health have welcomed the expansion of public health responsibilities to include a wider range of players (eg Wright 2007). However, the shift away from public health specialists requiring medical training towards a more inclusive approach has not been without opposition, as a series of debates in the *British Medical Journal* in 2000/2001 made clear (eg McPherson 2000; McPherson, Taylor and Coyle 2001). Wright (2007: 219) claims that medical resistance focused on concerns about whether the route open to non-medical specialists, a portfolio approach, constituted real equivalence with the route taken by medically qualified personnel to such specialist posts, or whether 'accreditation was merely entry to specialist status via a backdoor route, eg an easy alternative to higher specialist training'.

There were also concerns that public health might lose its critical mass, with Jessop (2002: 1) warning: 'NHS public health workers will be dispersed to the loneliness of 300 primary care trusts . . . they will face professional isolation, with hence an inevitable struggle to retain competence and sanity.' To counter the fragmentation of the public health workforce, the government announced the establishment of public health networks (Department of Health 2001b).

As Mallinson and colleagues (Mallinson, Popay and Kowarzik 2006) point out,

*it is important to distinguish Public Health Networks […] from other forms of self-defining and regulating networks […] [S]ince the establishment of PHNs was part of a centrally steered restructuring of health services, they are different from many of the networks described in […] academic literatures. This was, in part, why they were originally mooted as 'managed' networks.*

In practice, central government has provided very little steer on how public health networks ought to be structured, leaving their formation up to local decision-making. As might be expected, therefore, a variety of different types of public health network has emerged (Fahey et al 2003). For example, Abbott and Killoran (2005) have identified networks operating at four different levels of NHS organisation, with varying memberships and different conceptualisations of what the purpose and objectives of the networks are. So, in considering the role that such networks might play in countering fragmentation, there is a need first to clarify what is meant by the term 'public health network'. Fahey and colleagues claim:

*when a speaker/writer uses this term [public health network] the audience are often unsure if they are referring to a specific type of public health network, the government definition of a network, the faculty definition, or some all encompassing term* (Fahey et al 2003: 938).

Whilst there is some similarity between the various definitions (they tend to aspire to help pool expertise and skills in specialist areas of public health, share good practice, manage public health knowledge, and act as a source of learning and professional development), Fahey and colleagues highlight that there are also key differences. For example, in the Faculty of Public Health's (2007) definition, public health networks are expected to play a role in public accountability and in ensuring programmes can be performance managed, whereas *Shifting the Balance of Power* (Department of Health 2001b) explicitly states that public health networks are not linked to performance management regimes.

It is perhaps unsurprising, therefore, that in a survey of 60 public health professionals working in England, Fahey and colleagues found understandings of the term 'public health network' varied considerably from person to person and, overall, that their definitions tended to be somewhat broader than the government's. This research led Fahey and colleagues to construct their own definition of a public health network as:

*A network of public health professionals within a defined geographic area which facilitates communication, information sharing and linking of those with common interests/skills to enable efficient working across organisational boundaries to deliver the public health function* (Fahey et al 2003: 941).

More recently, a postal questionnaire survey of a random sample of members and fellows of the Faculty of Public Health Medicine by other researchers (Connelly, McAveary and Griffiths 2005) supports the idea that there remains no clear consensus about what a public health network is, even amongst public health professionals. The results found that 69 per cent of the 229 respondents reported that they felt 'public health networks' were inadequately defined, with the majority also suggesting that public health networks are under-developed and lack co-ordination, purpose and

structure. What seems clear from these findings is that public health networks have tended to focus on links between various public health *specialists* so it is unclear to what extent, if at all, this has progressed the multi-disciplinary nature of the public health workforce (Abbott et al 2005). In the light of this finding, some researchers (eg Mallinson, Popay and Kowarzik 2006) have criticised the trajectory of the development of public health networks to date for favouring a traditional public health function and membership.

There are also criticisms in terms of the extent to which the moves towards a multi-disciplinary workforce have actually succeeded. As Wright (2007: 219) points out, the new route for non-medical specialists was, in reality, open to relatively few senior professionals, 'leaving a disaffected and unsupported majority of the workforce in need of further training' to reach the levels of competence required. In 2001, the Health Committee (2001) claimed that the government had failed to redress the balance between healthcare and health (Hunter 2003; Baggott 2005). A year later, Evans and Dowling (2002) reported that significant barriers to multi-disciplinary public health remain, including a lack of clarity in terms of policy aims, as well as a continuation of non-equivalent training, registration and career pathways. And in 2003, Evans (2003) wrote:

*Despite the rhetoric of inclusion and equivalence, in practice there is continuing demarcation between medical and non-medical public health jobs. Regional director of public health posts and consultants in communicable disease control remain restricted to medical candidates. Non-medical directors of public health in PCTs earn between £15–20,000 less than medical colleagues apparently doing the same jobs. Although the FPHM has opened its examinations and membership to non-medical candidates on an equivalent basis, there are many structures that remain essentially uni-disciplinary.*

Closely related to the tensions between medical expertise and the drive for a multi-disciplinary workforce, long standing debates about the best location for the public health function have remained alive (Hunter 2003). The retention of the major public health function within the NHS is linked to the survival of the speciality of public health medicine and yet, Hunter (ibid: 111) claims: 'All available evidence suggests that the NHS, essentially a 'sickness' service, will never take the wider public health seriously.' The belief that it is irrational to maintain the location of most public health specialists within the NHS when most of the major levers for achieving public health's aims lie beyond the NHS is supported by the evidence from the first joint Director of Public Health to be appointed in England, Dr Andrew Richards, presented to the House of Commons Health Committee's inquiry into public health in 2001 (see Hunter 2003: 115).

**4.4 Local government and public health**

Since 1974, as we have noted, local government's engagement with the public health agenda has been problematic often for reasons to do with language and culture which have on occasion led to a virtual stand-off between local authorities and health service organisations (Elson 1999). Developments in neighbourhood renewal and regeneration, and concern about social exclusion in the late1990s have resulted in renewed interest in health issues in local government (Blackman 2006). Overview and scrutiny committees have sought to look at health issues more broadly and beyond the

concern with hospital closures or changes of use, and health and well being partnerships are developing joint strategies to improve health and address inequalities. But for the most part, local government has yet to seize the initiative in respect of health even though it is well placed to do so (Elson 2007). With the language issue serving as a barrier, terms such as 'wellbeing' and 'social responsibility' have been introduced to encourage local government to assume a leadership role and to stop believing that health issues should axiomatically remain the preserve of the NHS.

Notwithstanding a few dissenting voices, the weight of evidence submitted to the Health Committee's inquiry into public health did not favour returning to a pre-1974 style of organisation for public health (Health Committee 2001). Rather, in a world of constant change, the challenge was about working together wherever people are located and not about changing structures. But there was support for separating the public health function from the individuals doing public health in part to avoid confusion between health services and responsibility for health.

Realising the potential of local government to improve health has become a common refrain but with health seen as the business of the NHS it has been difficult to sustain a strong leadership role for local government. In theory this is surprising since the list of local government functions and services that act to improve the health and wellbeing of the local population exceeds that of any other public body (Local Government Association, UKPHA and NHS Confederation 2004). But, local government's vital role has been 'both obscured and undermined by the policy fragmentation which has separated policy on healthcare from the wide range of policies determining the conditions in which health can be sustained' (ibid: 14). Importantly, these latter policies 'have not enjoyed the same political salience as policies affecting healthcare' (ibid). Such a situation led the Health Committee to conclude that 'local authorities have yet to realise their full potential when it comes to public health' (Health Committee 2001: paragraph 129). A briefing paper for the Society of Local Authority Chief Executives (SOLACE) urged local authorities 'to reclaim their original role as champions of the health of local communities' (Duggan 2001: 2). But such a role would not fall to them by default. Local authorities 'must make the most of their unique position as community leaders to create a vision for health at local level and use their skills and resources to ensure that there is maximum impact on the health of local people' (ibid).

Returning to the policy focus on developing the public health workforce, Derek Wanless argued in his Treasury-sponsored review of the challenges and trends confronting the NHS that future health expenditure could only be reasonably contained by engaging the public in health and reducing risky lifestyle-behaviours (Wanless 2002). His second report, focusing specifically on the state of public health, perhaps not surprisingly found little had been achieved and recommended a range of changes, including an attempt to refocus the NHS from being an illness to a health service (Wanless 2004).

Published in the same year as the government's response to Wanless, and replacing its earlier health strategy, *Choosing Health: making healthier choices easier* (Secretary of State for Health 2004) highlights six key themes for public health – sexual health, mental health, tackling obesity, smoking reduction, reduction in alcohol intake, and

reduction generally in health inequalities – and emphasises the crucial role of the public health workforce in achieving the desired behavioural changes in these areas. Annex B of *Choosing Health* considers the importance of ensuring public health practitioners have the correct skills for their work in improving health, including a strong leadership capacity, and makes commitments to addressing critical shortfalls in specific staff groups.

An accompanying document published some months later, *Delivering Choosing Health* (Department of Health 2005), outlines the government's commitment to developing the public health workforce as a key means of improving health and tackling health inequalities. In the Supporting Strategy B of this document (pp.42-43), it is suggested that new contractual arrangements within the NHS ought to be used to engage primary care staff in improving health through everyday practice. This section also outlines the development of some new roles within the field of public health, including health trainers, which were proposed in the *Choosing Health* white paper. As well as encouraging local delivery and workforce plans to help identify gaps in the workforce, the document suggests a national workforce strategy and competency framework is required 'to underpin the development of education and skills and work across the health and social care community, local government, business communities and the voluntary sector.'

Around the same time, a separate government initiative, *Agenda for Change* (Department of Health 2004), aimed to bring the whole of the NHS workforce (with the exception of doctors and dentists) into a single pay framework. Although not specifically intended to unify the public health workforce, Wright (2007) argues that the changes this policy has brought about are leading to a coherent approach to job definitions and pay scales in public health for the first time.

The most recent relevant white paper, *Our Health, Our Care, Our Say* (Secretary of State for Health 2006), places further emphasis on the need to develop the capacity of, and skills within, the health workforce. It points out that currently very little of the money the NHS and social care sectors spend on training goes on training people in support roles and argues that 'it is not acceptable that some of the most dependent people in our communities are cared for by the least well trained' (Secretary of State for Health 2006: 188). The document goes on to make commitments to spending more money on training and support for the wider health and care workforce, and to developing joint service and workforce planning between the NHS and local authorities.

### 4.5 Non- governmental organisations and public health

It is generally accepted that non-governmental organisations (NGOs), including voluntary organisations and community groups, have had a significant part to play in the development of public health and that their potential to engage in healthy public policy decision-making should be encouraged (Scriven 2007). NGOs comprise international bodies, like WHO, national public health bodies advocating for improved health, like the UKPHA, national bodies set up by, but independent from, government concerned with aspects of public health, like the Food Standards Agency, and campaigning bodies which focus on particular public health topics or issues, like

the National Heart Forum, Nation Obesity Forum, Alcohol Concern and Action on Smoking and Health (ASH).

However, the precise role of NGOs in influencing policy or helping to shape the climate of public opinion over a public health issue is less easy to discern and does not appear to be well documented. In one of the witness seminars exploring the evolution of public health since the 1970s, the contribution of NGOs is specifically mentioned by one of the witnesses who singles out

*the big campaign groups who were identifying the health consequences of environmental issues, such as Greenpeace, Friends of the Earth. There was also a group I joined called 'British Scientists for Social Responsibility', I don't suppose that one's still going! But these were having an effect, not just in forming popularist opinion but in terms of influence, for example, on the Royal Commission on Environmental Pollution that actually brought about law on all kinds of things* (Evans and Knight 2006: 12).

However, documented examples of where NGOs have made a particular contribution are not plentiful, although this may be a reflection of the rather mysterious and opaque nature of policymaking in the UK (see Burton 2001). Nevertheless, such bodies remain an important sector of the public health system and clearly contribute in respect of highlighting problems, generating new thinking, providing a platform for those with particular expertise, and acting as channels for lobbying and advocacy efforts.

## 4.6 Health protection

Health protection is largely concerned with infectious disease control, chemical and radiological hazards, emergency planning, and the health care response to emergencies, including bioterrorism. In recent years, health protection has undergone significant change in respect of its organisation and location. The division of responsibilities for key public health functions was altered with the publication of *Getting Ahead of the Curve* (Department of Health 2002), which created the Health Protection Agency (HPA). This new agency, which was established to provide expertise on potential health threats such as infections and toxic hazards, took over much of the responsibility for public health protection. The creation of the HPA was the culmination of a number of changes in the nature and location of the health protection workforce since the mid 1970s.

Following recommendations made by the Acheson review in 1988, responsibility for public health and health protection passed to DsPH in DHAs, supported by specialists in communicable disease and their teams. With the 2002 NHS reorganisation, these responsibilities passed to DsPH in PCTs, supported by consultants in communicable disease control and performance managed by DsPH in health authorities. Problems of the dispersal of responsibilities (in a move from about 100 DHAs to over 300 PCTs) were addressed a year later, by bringing together national expertise (for England and Wales) in the new HPA in 2003. The HPA provides advice and support to the NHS, local authorities, the DoH and others. It operates at national, regional and local levels and has absorbed the Public Health Laboratory Service, the National Poisons Information Service, the Centre for Applied Microbiology and Research, the National Focus for Chemical Incidents, the National Radiological Protection Board and NHS

public health staff responsible for health protection. It also became the location for Consultants in Disease Control, with the exception of some community infection control staff who are based in PCTs.

The creation of the HPA has not overcome all of the perceived difficulties relating to health protection. In particular, disputes remain about the demarcation of the boundaries of health protection and the resulting accountability structures (Pickles 2004). In a study of variation in the interpretation of health protection arrangements between PCTs and local health protection teams, Cosford et al (2006) point to problems arising from the shift from the provision of health protection through a single organisation, the DHAs (which was the case until 2002), to the new dual statutory responsibilities for PCTs and the HPA. As they highlight, this shift has resulted in some confusion; whilst PCTs are still responsible for community control of communicable disease and non infectious environmental hazards, local arrangements for holding the HPA to account are based on a Memorandum of Understanding which has no legal or statutory basis. The ways in which it is implemented vary across England, partly as a result of the skills gap in health protection. The researchers demonstrated a number of health protection functions (five out of 18) where there was a lack of consistency and concordance between participants and between organisations: delivery of MMR vaccination following a student outbreak; infection control in private sector nursing homes; monitoring rates of sexually transmitted infections; immunisation training programmes for primary care staff; and investigation of an apparent cluster of congenital abnormalities. It is also claimed that while PCT public health teams are increasingly deskilled in health protection, formal accountability still lies with the PCT and not with the HPA (personal communication). Perhaps not surprisingly, the CEO of the HPA has, while acknowledging the 'tensions and setbacks' surrounding the setting up of the Agency, defended its overall record, claiming that it has 'enabled us to identify the gaps in evidence, move to more consistent delivery, and create teams with greater critical mass for more effective responses and proactive programmes beyond managing outbreaks of infectious diseases' (Troop 2007: 9). She also claims that bringing together Agency staff with frontline practitioners is 'beginning to demonstrate new ways of tackling old problems' and is, consequently, facilitating 'a co-ordinated national response to major emergencies'. Despite difficulties over the HPA's relationships with others charged with health protection responsibilities, a situation exacerbated by constant churn and organisational change within the NHS, there is probably general agreement that tackling the big issues around health protection demands a multi-levelled response, including national and international levels, and that a body like the HPA is therefore essential although it alone cannot deliver health protection. It must work in partnership with other relevant bodies (Nicholl 2007).

**4.7 Other developments**

Other important recent changes affecting public health included the incorporation of the Health Development Agency's responsibilities into the National Institute for Clinical Excellence in 2005. The new merged body, known as the National Institute for Health and Clinical Excellence, has retained the NICE acronym. To some, this move suggests a demotion in the importance of public health as compared to clinical work, locating public health firmly within the realm of the NHS. However, NICE has sought to work hard to engage with a wide range of stakeholders, particularly those beyond the NHS, and its focus on the evidence base for multidisciplinary public

health is retained within the Centre for Public Health Excellence within NICE (Kelly 2007). There is an acknowledgement that public health interventions are complex and multifaceted and give rise to particular issues and challenges that make them inappropriate to compare with medical or clinical interventions. The enlarged NICE is also taking forward the suggestion in Wanless' second report that studies of the cost-effectiveness of public health interventions ought to be undertaken. Indeed, it is one of the few recommendations in the Wanless report that has, so far, been acted upon. Nevertheless, given the location of NICE within the NHS, and its identity with evidence-based medicine and clinical cost-effectiveness, there remains an issue about how far its guidance is welcomed and received by, and/or can be expected to impact on, local government, where NICE is often not recognised and has little or no authority.

Important changes amongst the various professional groups involved in public health have also occurred in the last decade. For example, in 1999 the UKPHA was launched, formed from three pre-existing organisations: the Public Health Alliance, the Association for Public Health, and the Public Health Trust (which was the charitable arm of the PHA), with the aim of uniting the public health movement in the UK. Unfortunately, such unification has proved more difficult to achieve than expected, although perhaps this should come as no surprise given the failed attempts of earlier initiatives to bring together various different public health organisations. Indeed, the issue has once again risen up the agenda with the former Minister for Public Health, Caroline Flint, voicing concerns about fragmentation within the public health community and the number of bodies claiming to speak on behalf of public health. As a consequence, fresh moves are afoot to see once again if there is scope to bring together the key public health bodies, namely, the Faculty of Public Health, Royal Institute of Public Health (RIPH), Royal Society for the Promotion of Health (RSH), UK Public Health Association, and the Chartered Institute of Environmental Health Officers. As part of this rationalisation, in June 2007 the RIPH and RSH announced their intention to merge; the so-called 'Royal Wedding' is promised in early 2008.

**4.8 How far have things changed?**

Despite the promising policy rhetoric around public health, and the structural reorganisation of the public health function, and commitment to workforce development, the recent literature on the public health workforce makes for disappointing reading and does not suggest the problems outlined by Brackenridge (1981) and others over 20 years ago have yet been fully dealt with. Time after time, recent research on a range of different sectors and aspects of the public health workforce cites problems of under-capacity and a lack of clarity around training, career progression and inter-disciplinary working. For example, Brown's (2002) scoping study of the public health workforce in the North East, Yorkshire and Humber found a great deal of consensus within the workforce that it was under-capacity, under-resourced, had skill gaps, and that there were significant organisational difficulties in promoting collaborative and integrated working. The findings from this study (which are discussed further in Brown and Learmonth 2005) also indicate that problems around professional barriers and 'turf wars' were impeding partnership working, and that there has been little practical progress in terms of building capacity across the three levels of the workforce identified by the CMO (Department of Health 2001b; see also above) because of a lack of resources.

Various other studies on the role of public health nurses have found problems in training and associated gaps in skills, a lack of clarity of individuals' roles, and experiences of marginalisation from other members of the public health and healthcare workforces (Burke, Meyrick and Speller 2001; Latter et al 2003). Research on the role of public health specialists (e.g. Chapman, Abbott and Carter 2005; Chapman, Shaw et al 2005; Gray, Perlman and Griffiths 2005) identifies key skills gaps, a lack of clarity over the role of the specialist and the public health function, fragmentation and attrition of the workforce, and inadequacies in training and continuing professional development.

Around the same time that these various critical accounts were published, a report that had been commissioned jointly by the Department of Health and the Welsh Assembly Government (2004) with the aim of tackling some of these issues was also published. Acknowledging many of the problems outlined above, the report sought to help define the roles, functions and development needs of the specialist public health workforce. In the context of the white paper, *Choosing Health* (Secretary of State for Health 2004), this report particularly focuses on the health promotion aspect of public health specialists' roles. It recommends long-term sustainable staffing structures (and associated funding), a clear and recognised career pathway allowing free movement between the NHS and local government, and supporting education and training.

The prospects for better public health education and training may be constrained, however, as evidence suggests the academic side of public health is also struggling with a range of difficulties. A recent investigation into academic public health raises serious concerns about capacity and furthermore identifies significant problems with the funding of academic posts (Public Health Sciences Working Group 2004):

*The report highlights the extraordinary disparity between, on the one hand, the overriding importance of the public health sciences for public protection, service provision and health improvement and, on the other, the limited strategic interest that is taken in their infrastructure and conduct. Impressive achievements in the biomedical sciences and medical care can obscure the fact that the circumstances in which people live, whether these circumstances are under their personal control or not, are still the major determinants of health* (Public Health Sciences Working Group 2004: 2).

The report continues:

*It is a matter of concern that senior academic posts and academic leadership in the public health sciences receive relatively little support from central university funds, given the strategic importance of these subjects and their increasing role in educating the expanding numbers of medical students and other health workers. [...] The specialist service public health is in a state of change and this has led to the interface between academic departments and the NHS becoming unclear and in some places tenuous and fragmented. The expansion of public health interests and horizons ought to bring together a wider group of public health sciences. However, the current situation is not conducive to this being achieved because of fragmentation and the barriers to sustaining a critical mass of public health scientists (ibid: 18-19).*

Consecutive surveys of the specialist public health workforce, undertaken by the Faculty of Public Health in 2003 and 2005, highlight issues of under-capacity in the specialist section of the public health workforce (Gray, Perlman, Griffiths 2005; Gray and Sandberg 2006). The surveys indicate that there was a fall in consultants/specialists in public health of 17 per cent (224 individuals) in the UK between 2003 and 2005, reducing the overall level of total specialist public health capacity in the UK from 22.2 per million to 18.5 per million in 2005 (Gray and Sandberg 2006). The report's authors claim that the fall appears to have focused particularly on public health specialists working in the NHS in England and in universities. In addition, the surveys found evidence of significant regional variation in the distribution of public health specialists, widespread dissatisfaction with public health team capacity, and a significant proportion of specialists (17.6 per cent) who were considering leaving the speciality within the next five years.

Problems with under-capacity in the public health workforce are noted by the CMO in his 2005 annual report (Department of Health 2006), which highlights a deficit in public health capacity affecting the 48% of England's population living in the Midlands and the North. The report also suggests public health funds are being 'raided' to support clinical activities in some areas. In light of this, the CMO suggests that the lack of progress 'is more compatible with the Wanless 'slow uptake' scenario than with the 'fully engaged' scenario' to which the government is ostensibly committed (Department of Health 2006: 39). In conclusion, the CMO suggests consideration should be given to 'establishing a comprehensive review (the first in almost 20 years) into arrangements to improve and safeguard the health of the public' (Department of Health 2006: 45).

Whilst such a review seems unlikely, other developments have occurred. For example, following on from *Delivering Choosing Health's* (Department of Health 2005) recommendation that a national workforce and competency framework is required, plans to develop a coherent public health career framework for use across the UK are currently underway. This work, which is being undertaken by *Skills for Health and the Public Health Resource Unit* (on behalf of the Department of Health), aims to create a simple and easy-to-use tool which will facilitate collaboration and coherence across the diverse public health workforce. A consultation version of the public health skills and career framework appeared in mid 2007 for piloting across the UK and a post-consultation version appeared in September 2007 (Skills for Health and Public Health Resource Unit 2007). The framework, which is aimed at the development not only of the professional public health workforce but also the wider workforce, has adopted the generic NHS Career Framework as its starting point and modified it in the light of discussion. The framework consists of nine levels from initial entry to the most senior positions in organisations. Each level contains descriptions of the main competences and knowledge that would be required to work at that level. Public health work is based on various competencies (a combination of core areas, which everyone in the field is expected to have, and non-core areas, which apply to more specific domains of public health) which are a revised version of the 10 Areas of Public Health Practice that underpin the UK Voluntary Register for Public Health Specialists. The revised competencies already form the basis for the job description of Directors of Public Health (Faculty of Public Health 2006). The core and non-core areas are as follows:

Core areas:

- Surveillance and assessment of the population's health and well-being
- Assessing the evidence of effectiveness of interventions, programmes and services to improve population health and wellbeing
- Policy and strategy development and implementation for population health and wellbeing
- Leadership and collaborative working for population health and wellbeing.

Non- core areas:

- Health improvement
- Health protection
- Public health intelligence
- Academic public health
- Health and social care quality.

Following testing of the framework, necessary changes have been made to ensure that the framework is fit for purpose though it will continue to evolve. This will be especially important in the context of recent changes in public services, notably the NHS and local government. There is also unfinished business in hand in respect of public health leadership development and what further work might be undertaken in this area to provide appropriate leadership programmes for director level staff. One of the issues to be resolved is whether the Department of Health, perhaps working jointly with the NHS Institute for Innovation and Improvement and the local government Improvement and Development Agency (I&DeA), should offer national programmes or whether this is a matter for which the SHAs at a regional level should be responsible for undertaking.


# 5. Conclusion to Part 1

Part 1 of the scoping review of the public health system in England suggests there have been a number of consistent and recurring concerns about both the public health function and the workforce during the period from 1974 to the present day. Five merit highlighting:

- Lack of agreement over what public health is has resulted in tensions persisting between its technical-managerial role and its activist role.
- There is no agreed or shared philosophy governing public health with the result that old and new models of public health compete with each other, resurface from time to time, and jostle for position and supremacy instead of coexisting in a balanced approach.
- A never-ending succession of organisational reforms (especially affecting the NHS) has meant it has been difficult for people to settle in posts or embed relationships, particularly across agencies.
- There has been an ongoing debate about where the public health workforce should be located although it seems to be accepted that shifting the lead for public health from the NHS and back to local government would not resolve

the complexities that are intrinsic to the public health function; these are not susceptible to structural solutions and have more to do with cultures and perceptions of responsibility for health improvement that go beyond a narrow medical model.

- Despite a recent and welcome shift towards a multi-disciplinary workforce, the government's focus on training as a means to achieving this has left a gap in terms of agreeing a set of values to unite the public health movement. Moreover, recent research suggests the public health workforce is currently under-capacity in every sector although so far nobody has come up with an agreed model to determine what that capacity should be (Rao 2007).

Overall, although now more multi-disciplinary in nature, at the same time the public health community is also more fractured and disunited with a persistent lack of clarity about roles. All this supports Hunter and Sengupta's (2004: 4) claim: 'There remain serious concerns over the purpose of public health, and over the capacity of the workforce and its capability to deliver what is required.' As Beaglehole and colleagues suggest, and returning to a central theme of the last section, the problems facing the development of an effective, multi-disciplinary public health workforce are closely tied to the question of what public health is: 'If public health practitioners are to address national and global health challenges effectively […] a clear vision of what public health is, and what it can offer, is required' (Beaglehole et al. 2004: 2084). A failure to achieve this sense of unity will result, Wills and Woodhead (2004) claim, in public health continuing to be marginalised, and not forming the central concern of any of the various professions deemed part of public health.

These issues are by no means unique to this period in time within England (Scally and Womack 2004) or, indeed, to England (Beaglehole et al. 2004; Tilson and Gebbie 2004). For example, former WHO Director General, Lee Jong-wook (2003), raised similar concerns in the international context:

*progress will at best falter if the capacity issues in public health continue to be ignored or downplayed, if the medical dominance of the speciality reasserts itself, or if the absence of a shared set of values hampers an integrated approach across disciplines and agencies.*

Furthermore, in a recent review of the public health enterprise in the USA, Tilson and Berkowitz (2006) cite a range of challenges to public health similar to those described in England, including a lack of clarity about the public health function and lines of accountability, gaps in competency, skills and training, and a paucity of good research.

It may be that adopting the concept of the public health system might offer a way of tackling some of these tensions and deficits since simply revisiting them every now and then and coming up with the same analysis and prescription has not resulted in significant progress in improving the public's health despite the mounting challenges facing it. Section 3 above has elaborated on what is meant by such a system and how it might be applied, taking advantage of the diverse sectors and range of expertise which would not axiomatically be regarded, or regard themselves, as having a major contribution to improve the public's health. Perhaps trying to get agreement on a definition of public health and regarding the workforce as comprising only those with

public health in their job title should give way to a focus on the public health system as a complex system with multiple facets and resources, and to accessing its relevant components according to the particular public health task requiring attention. Indeed, given the difficulties of defining the public health workforce and determining who should be doing what with what range of skills in respect of a wide range of functions, it may be more sensible to worry less about such issues since resolving them to everyone's satisfaction seems unlikely and a forlorn hope. We should focus instead on clarifying the nature of the public health system.

In Part 2 of the scoping study we examine the relevance of the public health system and its application to the emerging configuration of public health as a consequence of the changes in the NHS and, to a lesser extent, local government.

# Part 2: The State of the Public Health System in England: the impact of policy and organisational changes since 2004

## 6. Background

In this second part of the scoping study, we examine the relevance of the public health system and its application to the emerging configuration of public health as a consequence of recent policy (see Appendix 2 for a map of key policy documents published since 2004) and organisational changes, in particular the NHS reorganisation in England which is still working its way through the system and has been heralded as the most far-reaching of the many reorganisations in the Service's history (Hunter 2006). Each such reorganisation has had a significant impact on the public health system, as the Chief Medical Officer (CMO) for England has noted in his two most recent annual reports for 2005 and 2006 respectively (Department of Health 2006 and 2007b). Despite the change in prime minister, a new team of health ministers, and changes in departmental structures and responsibilities with the creation of a new Department for Children, Schools and Family, so far there does not appear to be any notable shift in the substantive direction of the reforms. Indeed, further reform seems likely given the appointment of Lord Darzi, a world-renowned surgeon, as junior health minister tasked with reviewing the future shape of the NHS in England under the heading *Our NHS, Our Future*. If his report on the future of the NHS in London is any guide, two key principles of relevance to public health are likely to feature – prevention is better than cure, and a focus on health inequalities and diversity (Darzi 2007). And, indeed, these elements feature in his interim report rushed out in October (Department of Health 2007c).

What is evident in the months since the new prime minister entered office is a change in atmosphere around the health reform agenda. It appears to be less frenzied and efforts have been made to be more inclusive in order to win support among staff groups, especially clinicians, for the changes. Lord Darzi's appointment carries with it a specific brief to engage with clinicians and ensure that the reforms, present and future, are informed and 'owned' by frontline practitioners rather than imposed from above.

It may also be that such a change in style reflects a new, and more sober, mood in the Department of Health following a Cabinet Office capability review which gave a damning verdict on its poor leadership and lack of strategic direction (Cabinet Office 2007). Much of what the review has to say is of direct relevance to the public health agenda and to the notion of a public health system as we have used the term (see Part 1, Section 3). The review notes the health risks of modern lifestyles and asserts that the Department 'will need to work in closer partnerships with other organisations to meet these challenges and to make its full contribution to broader social policy' (ibid: 15). Of particular relevance to the public health workforce, the review states that meeting the challenge will require 'delivery expertise appropriate for this wider environment'. Perhaps of most significance, the review concludes that the Department 'has not yet set out a clearly articulated vision for the future of health…and how to get there' (ibid: 18). It goes on to say: 'there is currently no single clear articulation of the way forward for the whole of the NHS, health and well-being agenda. Consequently, staff and stakeholders are unclear about the vision for

health and…feel little sense of ownership of it'. Too often, the review claims, the Department operates 'as a collection of silos focused on individual activities' (ibid: 19). In particular, policies 'tend to be developed in organisational silos and cross-boundary integration issues are not routinely thought through' (ibid: 21). The review is also critical of the absence of front-line staff engagement in the development of policy and suggests that this results in a lack of common ownership of outcomes. In a section on key areas for action, the review insists that the Department needs to construct 'a credible picture of how the whole system will make improving health and well-being its primary focus in the future' (ibid: 25).

The top management team in the Department of Health, comprising the Permanent Secretary, NHS CEO and CMO, acknowledges that the Department needs 'to raise its game on staff engagement and corporate leadership' (ibid: 7). Later than promised, the Department of Health's top team has produced a development plan in response to the capability review (Department of Health 2007d). However, this brief document says little of substance in response to the specific criticisms levelled at the Department and comprises a lengthy series of actions to be taken over the next year and beyond in three phases. Over the next six months, the Department will 'set out an overarching high level vision for health and well-being' which will be shaped by the comprehensive spending review, and the *Our NHS, Our Future* review of the NHS being led by Lord Darzi (ibid: 4). In 12 months, the Department will 'continue to develop…a shared vision for health and well-being,…develop a clear narrative on how the vision will be realised', and 'strengthen our arrangements for working with local government, regional offices and locality based stakeholders' (ibid). In 24 months, efforts will be made to 'ensure coherence with wider strategies of other government departments' (ibid).

The conclusions from the capability review, and initial response to it, have been reported at some length here because they provide a useful context against which to present much of the material collected for this second part of the scoping study. They also lend weight to, and are supportive of, many of the emerging themes and issues identified by our interviewees especially those in respect of the government's commitment to public health, to tackling health inequalities, and the perception of policy changes in recent years which do not all seem to be coherently aligned.

## 7. Approach and Methods

Given the understandable paucity of published material on the recent (and, indeed, ongoing) changes in the NHS and related areas and their actual and potential impact on the public health system, it was decided that the only viable means of obtaining reliable material to inform the second part of the scoping study was to carry out a series of in-depth interviews with key stakeholders at different levels and across a range of organisations comprising the public health system. A total of 28 interviews were conducted between May and July 2007 (the majority, 26, were conducted over the telephone but two, at the request of interviewees, were conducted face-to-face). Interviewees were drawn from the following organisations and the number of interviewees in each category is given in brackets:

- Department of Health (4)
- Strategic Health Authorities/Regional Government Offices (9)

- Primary Care Trusts (6)
- Local authorities (3)
- NGOs (5)
- Professional bodies (1)

Most of those interviewed were already known to members of the research team which facilitated access, although the actual interviewer did not know the majority of interviewees and none of them well. An initial list of potential interviewees was constructed, based on the research team's knowledge of the field. Other interviewees were suggested to the researchers as the interviews progressed and several of these were subsequently followed-up to ensure the interviewees reasonably reflected a cross-section of the public health system's component parts.

The interviews sought to elicit views on various aspects of the public health system and the current and potential impact of the recent changes. The full interview schedule is reproduced in Appendix 3, although it was adapted, as appropriate, to reflect the particular interests and position of interviewees. Generally, however, all the interviews explored the following issues:

- the degree of 'fit' between the evolving public health system and the public health challenges that it needs to address
- the implications for public health service delivery of national policy priorities
- the impact of recent policy reforms on the management, organisation and delivery of public health services
- the changing composition and shape of the public health workforce.

All of the interviews were transcribed in full and then coded using the qualitative data analysis programme, *Atlas.ti.* The coding framework was developed through a combination of thematic coding, based on the interview schedule, and *in vivo* (bottom-up) coding for issues which emerged in the data and which were not already captured by the thematic framework. All of the data were fully anonymised prior to the circulation of written material beyond the immediate research team in order to protect the identity of interviewees (something which we had guaranteed to interviewees in advance of the interviews in order to allow people to talk more freely than they might otherwise have felt able to). For the purposes of this review, the interviewees are labelled according to the type of organisation in which they were based at the time of the interview (ie those organisational types listed above). However, it is important to underline that the interviews were designed to solicit respondents' personal reflections and views, and interviewees were specifically encouraged to draw on their own experiences. Consequently, interviewees should not be perceived to be speaking on behalf of the organisations in which they were based and/or for which they worked.

The remainder of Part 2 is structured around the six key themes and issues which were inductively derived from the analysis of the interview material. We consider these in the following sections:

- The changing policy landscape in England post-2004 (Section 8)

- The public health system and its capacity to meet public health challenges (Section 9)
- Impact on the organisation and management of the public health system of commissioning, partnership working, and public involvement (Section 10)
- Markets and choice (Section 11)
- The changing public health workforce (Section 12)
- Looking to the future (Section 13).

A brief commentary on the material reported from the interviews, linking it to the historical review in Part 1, is provided in Section 14. It summarises key issues and themes of an enduring nature and assesses these in regard to the extent to which it can be said that a well-functioning public health system either already exists or might be expected to emerge in the future. Finally, Section 15 provides a brief conclusion to the review.

Not surprisingly, given the recent time-frame, there have been few independent studies of the policy and organisational changes since 2004 or their impact on the public health system. While some aspects of the changes have been subject to limited scrutiny and assessment (see, for example, Fotaki et al's (2006) critique of the choice agenda; Green, Ross and Mirzoev's (2007) analysis of the changes in primary care and their relevance for public health; the House of Commons Health Committee's analysis of the changes in primary care and the NHS more generally (Health Committee 2006); and a recent edited collection assessing New Labour's failure to tackle health inequalities (Dowler and Spencer (eds) (2007)), the majority of these commentaries have not focused exclusively on public health and/or have not incorporated the changes which have taken place over the past year or so. One exception is the stocktake undertaken by former government adviser, Derek Wanless and colleagues, on behalf of the King's Fund (Wanless et al 2007). Even so, their focus is largely confined to issues around NHS productivity, efficiency and value for money and to establishing whether sufficient added value has been achieved from the injection of new resources which occurred after Wanless's first report in 2002 (Wanless 2002). Nevertheless, Wanless and colleagues are critical of the slow progress being made in some areas of public health, notably obesity, despite the framework for action and route map set out in Wanless's second report (Wanless 2004). Furthermore, many of Wanless's criticisms concerning the negative impacts of the frequent restructuring of the NHS, and the weak state of the workforce, are echoed in the views of the individuals who participated in this scoping study.

Notwithstanding the literature referred to above, it is fair to say that no recent study has been published which endeavours to look at the whole public health system and the interaction of its various component parts. Given the dearth of accounts of how the policy and organisational changes have impacted, or are likely to impact, on the public health system, our modest and limited study probably represents the first detailed contemporary account of how the changes are being perceived by those engaged in their implementation and what they are thought to hold for the future development of a public health system. However, we are aware of a joint study that is currently being undertaken by the Healthcare Commission and Audit Commission entitled *Are we Choosing Health?,* which commenced in July 2007 and is expected to be published in January 2008. This study is exploring the impact of 10 years of policy on public health delivery and outcomes by looking at services – what they are, how

they are organised, and the way they are delivered.  The study will identify which policies have helped, which have hindered, and which seem to have had little impact on delivery.  Given the overlap between this study and the scoping review reported here, we have maintained close contact with the public health team at the Healthcare Commission who are leading the joint study and, drawing on the issues that have emerged in our interviews, we have contributed to the issues and concerns the audit is investigating.

To sound a note of caution, it should be stressed that what we have undertaken in this scoping review amounts to no more than a snapshot of opinions at a particular point in time. Given the dynamic and ever-shifting nature of the policy context, it may be expected that the views reported here will change over time.

In the six sections which follow – Sections 8-13 – we discuss responses to each of the six themes described above.  In each case, we include a brief commentary on relevant policy developments, where appropriate, to provide some context to the interviewees' comments and views.


## 8.    The Changing Policy Landscape in England Post-2004

In describing and explaining their own perspectives on the desired policy approach to public health issues in England, and in the context of post-2004 developments such as Wanless' (2004) review of the state of public health and the public health white paper, *Choosing Health* (Secretary of State for Health 2004), all our interviewees were clear that they felt it was essential to focus on wider determinants of health as well as individual lifestyle behaviours, especially in the light of the ongoing commitment to reducing health inequalities.  However, there was less of a consensus about the extent to which recent policy had focused on each of these two aspects.

Interviewees' views reflect a more general degree of uncertainty and confusion about such matters in government.  For example, the former prime minister's speech on public health issues, delivered in July 2006 as one of a series of major speeches on public policy issues, insisted that the new challenges facing society related to smoking, poor diet, alcohol misuse, sexual behaviour and were, therefore, not public health questions at all but 'questions of individual lifestyle' (Blair 2006).  Yet, despite the emphasis on individual lifestyle, evident in the former prime minister's speech, the policy picture is rather more mixed and confused.

In respect of smoking at least, the government, in the end, opted to support legislation to ban smoking in public places, suggesting that there is some acknowledgement that central government intervention may be required, and even desirable, for public health objectives to be achieved.  Likewise, new nutritional standards have been introduced in all state schools across England in response to criticisms of the low quality and poor nutritional content of school meals.  Nevertheless, many observers (as well as some of our interviewees, as we report below) viewed Tony Blair's speech as evidence of a decisive shift in government thinking and a deliberate attempt to deflect any accusations that the 'nanny state' is alive and well.

Under Gordon Brown's premiership, however, there are signs that there may be a change of direction underway. On gambling, for example, Brown has intervened to prevent the super casino from going ahead in a deprived area of Manchester asserting that there must be other ways of tackling regeneration in deprived areas (although plenty of opportunities for gambling still exist). On alcohol, the government is under pressure to do something about under-age binge drinking which is seen to reflect in part the widespread availability of cheap alcohol (Academy of Medical Sciences 2004). In addition, in his first major speech as the Secretary of State for Health, Alan Johnson, tackled the subject of health inequalities (Johnson 2007). Reviewing the government's record and achievements, Johnson acknowledges that while life expectancy and infant mortality rates have all improved in the last decade 'the depressing truth remains that we have not made enough progress in reducing health inequalities'. He claims that this is not a reason for 'donning sackcloth and ashes' as governments everywhere are struggling to reduce widening inequalities with only Sweden possibly achieving any real success.

Restating existing government policy, the Health Secretary wants health inequalities fully integrated into NHS commissioning and sees his role as improving the health of the nation while ensuring that the health of the poorest improves the fastest. A strategy on tackling health inequalities is promised for next year which will set out 'a bold new work programme' covering the two priority areas of access and prevention. Rehearsing a familiar line from successive health secretaries over the years, a priority for Johnson is to shift the approach from being 'treatment oriented to being prevention oriented, altering our focus from sickness to health'. He endorses the Wanless thesis that the future of the NHS depends on encouraging people to take better care of themselves. Although noting the important role that government has in promoting health, insisting that it cannot afford 'to be the passive observers of unhealthy lifestyles' and that public health issues 'must be elevated to the top of the national agenda', it is not clear if a change in direction is envisaged. Although the emphasis on encouraging healthy lifestyles remains, Johnson believes that the public may now be less concerned about 'a nanny state than they are about a neglectful state'.

Whatever the future may hold, during the period when these interviews took place (which bridged the change in leadership from Blair to Brown), there was a consensus that Department of Health policy had shifted towards a greater focus on individual lifestyles and that performance management systems did not serve to prioritise public health. Reflecting the shift towards lifestyle approaches, the majority of our interviewees felt that recent policy approaches had focused overly on interventions designed to address individual lifestyle behaviours to the detriment of broader, more upstream interventions. For example:

DH: *'I think we've probably gone a stage too far in terms of personalising it all because you can then start to push up against, 'it's every single individual's fault that they've got poor health.' I think we have to get a balance here. [...] Because we know in some of the disadvantaged areas, people can't make those healthy choices, and it's the factors that are around them that stop them making those healthy choices...'*

NGO: *'Although there's been some rhetoric and [...] White Papers about health, particularly health inequalities, being related to things like deprivation, it's not*

*politically central at all. And I think that reflects on local politics, so local politicians are very much driven through the national agenda.'*

For many of the interviewees, the 2004 public health white paper, *Choosing Health*, marked a key point at which there was a noticeable shift in central government's focus away from the broader determinants that had been so much discussed immediately after the 1997 election victory, and towards individuals and their lifestyle behaviours:

PCT: *'Choosing Health has got more in it than just lifestyle stuff but, in the kind of reductionist way we approach things, I'm afraid they're the bits which have come out of it and which are being actioned, rather than the other bits.'*

SHA: *'I think the policy focus in* Choosing Health *was very much on an individual choice approach which was wrong and, given that* Choosing Health *came out in 2004 and it had so little impact [on public health outcomes], I think that's [been] borne out by experience.'*

DH: *'I think possibly communications around and following* Choosing Health *went a little bit overboard on individual responsibility, and I think we're sort of stepping back a little bit from that now and trying to get that balance.'*

Whilst some interviewees seemed keen to reflect on their disappointment that the three Labour governments in power since 1997 had not taken a more radical approach to public health, others acknowledged, in keeping with the views expressed in the former prime minister's speech mentioned earlier, that recent public health challenges have been shaped by broader societal trends, such as a growing consumerist culture, which are not necessarily politically easy to address. Nevertheless, many of the interviewees felt the government could, and should, be doing more to address these issues:

SHA: *'We have a lot of influences driving people to live unhealthy lifestyles which are relatively unchallenged. For example, the food industry and the tobacco industry are set up to make large amounts of money out of persuading people to behave unhealthily. We see that in their advertising strategies and so on. So to leave that unchecked and then suggest that personal choice and personal responsibility should be the key driver is really very unfair.'*

NGO: *'My opinion [is that], in the last 20 years, one of the big changes has been the fact that we've had massive changes in consumption patterns, driven by marketing, which is completely unregulated. And people don't have access to basic tools to be healthy...'*

In the face of these broader, societal trends, several of the interviewees seemed disappointed with the levels of public and voluntary sector advocacy in regard to public health issues. For example:

SHA: *'I think some of the wider lobbying and advocacy work that organisations like the UKPHA were at one time doing has diminished. So part of the whole system for public health, which was the mobilisation of public outrage, is lacking...'*

On a more positive note, many of the interviewees saw the recent ban on smoking in public places as evidence that national legislative action was possible and, if effectively promoted and explained, would receive public support:

Local government: *'I guess individual choice is important and informed choice is important, but if we don't have the infrastructure to enable people to do that, then... That's why I think smoke free environments and the smoking ban are fantastic - it's the only way to do it, Tony Blair.'*

PCT: *'The smoke-free legislation that's about to come into effect will have a big impact on public health, I have no doubt, and that is archetypally society making a decision about the things that lead to individual decisions, rather than just leaving it up to individuals.'*

Additionally, some of the interviewees felt that the sense of disappointment at the limited nature of policies to address the wider determinants of health came not from a lack of activity in these areas but rather from the way in which policies have been badged. So some of the interviewees claimed that the Labour governments since 1997 *had* pursued policies designed to address key social and economic determinants of health, such as housing, regeneration and education, but that there had been a failure to promote these activities effectively to the public or to link these broader policies to the public health agenda in a coherent or convincing narrative:

NGO: *'If you look at other kinds of policies, like all the work on the national strategy for neighbourhood renewal, [...] the kind of community cohesion agenda, if you think about some of the stuff that's been done in relation to equalities around race and gender and sexuality, for example, which might not be called public health policy or might not even actually have been evaluated in public health terms, then I do think they will have had an important contribution to those broader kind of determinants. I think the problem is perhaps some of the ways that we've articulated the public health [agenda].'*

NGO [different interviewee to above]: *'I think the Government actually has a fairly broad strategy [but] I think they describe it badly. Let's take an example, the Food and Health Action Plan that the Government has, I think [it] is the most progressive and comprehensive plan on food and health anywhere in the world. And it's not just about individual lifestyles, it's about changing the nature of the food economy and culture. [...] So it is not just an individual lifestyle approach. I think it's unfortunate the politicians, when you talk about those things, that they don't actually describe the bigger picture, and that's probably because they're afraid of being accused of being nanny stateish. But the reality is, it is a comprehensive approach.'*

Local government: *'I think I can give you examples of some good work which has come through different government departments, particularly in the housing field where the new Housing Act's legislation clearly has a lot of provisions in it which are going to tackle some of the poorest housing. [...] So that wasn't put in fundamentally as public health legislation, but as legislation per se, it's going to have an enormous impact on public health, in fact, that's one of the examples I'd cite as having a bigger impact than all of the stuff we might do, for example, on lifestyles. I suppose, my*

*perspective would be that the Government are perhaps missing a trick in not including all of those things in the basket of things that they take credit for that they're doing to improve public health.'*

However, it is perhaps a reflection of the weak or limited connectivity between broader policies aimed at issues like regeneration and those which specifically focus on 'public health', as usually defined, that only a few of the interviewees, despite being concerned with deprivation, poverty and so on and the lack of attention they were receiving, specifically mentioned Neighbourhood Renewal Funding in relation to public health activities. Yet these kinds of policies are surely a key component of any holistic public health system, certainly as we have defined it (see Part 1, Section 3). Whilst a few of the interviewees suggested that the recent emphasis on local flexibility and local government involvement had improved the possibilities for addressing wider determinants of health at a local level (sometimes despite national guidance which seemed to run counter to, and contradict, this thrust), several felt that nationally set targets and incentives relating to public health were actively promoting (intentionally or unintentionally) downstream public health interventions. In particular, the prominence of activities relating to secondary prevention, such as statin prescribing for individuals deemed to be at risk of heart disease, and smoking cessation were both highlighted. None of the interviewees felt that these kinds of activities were, of themselves, either problematic or inappropriate but many seemed to think that this emphasis had overshadowed more upstream approaches and had shifted the focus of public health activity at the local level. For example:

NGO: *'There's suddenly a recognition that the 2010 targets aren't going to be met in all sorts of places, and so what people now I think are now scurrying around to try and do is say well, 'what do we know the NHS can definitely deliver between now and 2010?' So let's get as many smoking cessation services in place, let's prescribe more statins and basically do the medical and healthcare bits with a real view to meeting 2010 targets. Now all of that is absolutely fine and reasonable, and it's quite right that the NHS should be doing its bit to, but the danger of that is that we take our eye off the ball. In particular, that NHS Chief Execs take their eye off the ball, from the wider determinants.'*

Local government: *'Some of the [public health targets] are quite clearly supporting healthcare, which is no bad thing but that's a small part of it. If you look at the classic Dahlgren & Whitehead diagram, health care services make up a very, very small part of what determines people's health. So yes, okay, if you can respond better to people who are having heart attacks, that's good but the floor targets and so on don't really help you much with prevention. I suppose, they do in terms of smoking. We certainly want to encourage smoking cessation but, again, that's possibly after the horse has bolted.'*

DH: *'I have to say I don't really think that statin prescribing is really about public health, I think it's about individuals' health and I don't think we're improving the health of the nation by giving people statins. We're merely reducing the risk across the population of a certain percentage of people having strokes and heart attacks. I mean that seems a desirable outcome but it's not what I think of as improving health [...] it's reducing risk of ill health.'*

Such a shift towards downstream interventions within the NHS seems likely to remain, at least for the time being, since, as the Darzi review of the NHS in London states, health improvement 'should be embedded in everything the NHS does' with staff being incentivised to promote physical and mental health (Darzi 2007: 7). While this may be an entirely laudable objective, and has certainly been an overlooked area of concern, it does beg the question of how to ensure a balance between downstream and upstream interventions with a danger that short-term pressures and a search for 'quick wins' will distort the nature of the public health response and task at least as far as the NHS is concerned.

Many of those we interviewed felt the difficulties of meeting appropriate public health targets and implementing effective public health incentives in the context of a high turnover of senior management (especially chief executives) in PCTs, and the extreme pressure placed on them to meet other targets, particularly financial ones and those connected to reducing waiting lists, notably the 18 week wait target which is dominating managers' and others' agendas. For example:

SHA: *'One of the problems with the 2010 targets is that chief executives, when they got these targets several years ago, were not at all interested in the long term targets running up to 2010 because that's two or three chief executives away. They wouldn't even be around so why should they care? So those targets were ignored until probably in the last year or so. Now they're waking up to the idea that they need to hit these targets, and so they're looking at all of the short term measures around secondary prevention which will help them get to that target, and they'll probably get to the target and then forget about it, but in the meantime the long term stuff is being ignored.'*

PCT: *'I'm just wondering how relevant they [public health targets] are at all, actually. I've been in a PCT that's had a massive deficit and it seems to me that there are only a few things that matter and that is financial balance and financial balance.'*

DH: *'The way it works is that the NHS, [the message is] 'you've got to do all these things but don't get the money wrong!' If you don't do all these things, people will complain. If you get the money wrong, you'll be sacked. So there's a difference between the espoused philosophy and the philosophy as it works out in practice.'*

Whilst most, though not all, of the interviewees were generally supportive of the need to have some kind of nationally set public health targets, nearly everyone we spoke to felt that the present targets and performance management systems in place in England were either ineffective or actively detrimental to public health aims. The key point, captured in the above quotations, is that public health targets are not given the same priority as other targets at local level, and are not thought to be as rigorously performance managed. These points are borne out by the findings from an earlier study which examined the obstacles to the NHS of giving a higher priority to public health (Hunter and Marks 2005). In addition, a couple of the interviewees expressed frustration at the lack of connectivity between various sets of targets and between the contrasting performance assessment systems relating to different sectors:

SHA: *'I think there is an issue about different parts of the system having different objectives, or not having objectives at all.'*

SHA [different interviewee to above]: *'One of the problems we've had is that local government have not had the same targets as the NHS and are prioritised differently. So if we had the same targets for the organisation, so that they were performance managed on the same things - and that's started to happen now throughout LAAs - then that can certainly help.'*

As the second quotation above illustrates, some of the interviewees were hopeful that recent policy developments, especially relating to Local Area Agreements, might improve the connectivity between targets and performance assessment measures, at least between PCTs and local government. However, there was also widespread concern amongst interviewees that the current incentives and targets tend to focus overly on processes and not enough on outcomes. On this point, there appeared to be less optimism that the issue would be tackled by recent and forthcoming changes:

SHA: *'The [current] performance management is around processes, which are easy to measure, and they're not really about outcomes. And one of the problems is that we don't have a clear connect between the processes that we performance manage and the health outcomes that are achieved. [...] Public health effort should be measured, at least in part, against the differences they make to the communities they serve.'*

SHA [different interviewee to above]: *'You can always come up with lots of excuses for why your population is becoming unhealthy, and you can fail to address the issue, so it requires a focus on the outcome itself and also on ensuring that you're doing all of the things that you should reasonably be doing to achieve that outcome. [...] And then if [local bodies] are doing that and not achieving their target [...] then we should be calling then to account.'*

The frustration that many of the interviewees expressed in relation to the failure to focus targets and performance management on public health outcomes was often articulated in relation to a broader sense of disappointment with regards to recent trends in public health outcomes. The lack of success in attempts significantly to narrow various forms of health inequality was an issue which many interviewees highlighted as an example both of the need to focus on outcomes and also of the need to implement, with greater vigour and commitment, more upstream, preventative measures to improve health and reduce inequalities over the longer term. The persistent difficulty in shifting the NHS policy agenda and public health activities towards this end of the spectrum, however, seemed to have left many of the interviewees feeling rather frustrated and despondent, with several expressing disappointment that the Wanless (2002; 2004) reports had not been more influential in respect of the public health agenda, a conclusion with which Wanless himself would probably concur in the light of his review of progress with his 'fully engaged scenario' since 2002 (Wanless et al 2007):

PCT: *'Derek Wanless was the brave person who tried to actually say, 'We cannot expect to carry on unless we do this fully engaged scenario'. And Wanless seems to have sort of gone slightly off the radar as far as I have spotted recently but we need to perhaps reinvent it in the current commissioning climate.'*

PCT [different interviewee to above]: *'[It] was terrific that we had the Wanless Reports and what was so ghastly was that … the ink had hardly dried and they seem to have been ignored.'*

One of the biggest recent disappointments for many of the interviewees seems to have been the failure of PCTs to use most of the money made available for public health through the implementation of *Choosing Health* (Secretary of State for Health 2004) on public health issues. This issue is explored in further detail in Section 9, sub-section 9.3.5. For some, the 'snaffling' of *Choosing Health* monies to deal with PCT deficits highlighted the broader dangers of locating public health responsibilities with NHS bodies. Many of the interviewees based in, or with connections to, local government, as well as some of the DsPH and RDsPH, felt that retaining public health in the realm of organisations which were inevitably likely to face ongoing financial pressure, would, in all likelihood, mean that public health continued to be de-prioritised. For some interviewees, and however unlikely, this led to the conclusion that public health would be more effectively promoted if it was separated from the NHS and Department of Health:

SHA: *'I don't know how you overcome the funding problem because that* Choosing Health *money was seemingly given in a very open way and PCTs have used it to deal with pressures that they were under in a number of different ways and … if the PCT's culture is not one where it recognises invest-to-save or cost benefit, then you're always going to have money spent on short-term fixes rather than a long-term preventive work. [...] I think* Choosing Health *is a case study to prove that resourcing public health activities through the NHS is not safe.'*

These suggestions raise bigger issues about the broader organisation of the public health system in England, issues which are discussed further below in Section 9, sub-section 9.3.4.

## 9. The Public Health System and its Capacity to Meet Public Health Challenges

In Part 1, Section 3, of this scoping review we discussed different elements of a public health system and in the first part of this section we outline how our interviewees conceptualised the notion of such a system (sub-section 9.1). Differences in definition are inevitably underpinned by how public health is defined and the values which underpin it, an issue explored in sub-section 9.2. Drawing on the first two sub-sections, sub-section 9.3 draws out the key issues identified by interviewees as essential to an 'ideal type' public health system, and considers how these relate to interviewees' conceptions of the status quo. Sub-section 9.4 then considers interviewees' perceptions of recent policy initiatives relating to the public health system.

### 9.1 What is a 'public health system'?
Nearly all of the interviewees defined their ideal 'public health system' in very broad terms, as something which should encompass far more than the organisations and individuals with public health in their titles:

PCT: *'Ideally, the Public Health System would include all of those elements of the socially created environment - the policies, the institutions and the means by which we govern ourselves that have an implication on health.'*

PCT [different interviewee to above]: *'I think it is all the elements required to deliver public health programmes in a connected and joined up way, at various levels. So, it's not just local level, it's how the system actually comprises things that are local, regional and national level as well. So interconnectedness across and also up and down.'*

NGO: *'I think you start at the top and go right to the bottom so my view at the top would be a Cabinet level post of very high seniority with a minister within each department responsible for reporting to that person and being responsible for health in practice etc and public health issues throughout their directorate, or their department, so that's transport, obviously, a major one economy, another major one for sitting on inequalities and poverty, housing. I mean it just goes on and on. Clearly, it's a cross governmental issue...'*

However, when discussing the current public health system, several of the specialist health professionals (DsPH and RDsPH) focused rather more on definitions developed by the Faculty of Public Health and public health professionals. For example, the Faculty of Public Health's (2007) 'three domains' of public health (see Part 1 above, Section 3.2) and the CMO's three-part definition (see Part 1 above, sub-section 4.3) were both cited. As well as contrasting with the far broader ways in which most of the interviewees described an ideal public health system, this approach was significantly different from the descriptions provided by interviewees based in, or with strong connections to, local government. These interviewees tended to emphasise the limited nature of specialised, NHS based public health professionals and organisations. For example:

NGO: *'They [the NHS] are only small, part players in the total picture so, in my view, far more important than the NHS is getting local government onside because it's local government that will make or break the building blocks. And if you think about who's important, it is the planners, it's the regeneration people, it's the licences, it's the array of different services. We think of social services and children's services but it's all the others that exist alongside that. And then, outside the local authorities, you get into other government departments. The DWP is very important. So, for me, getting local government owning the issue of health improvement and being committed to making changes in this will be every bit as important as what happens in the NHS.'*

Local government: *'I view the public health workforce as not just the NHS employed workforce, but I think that that is not necessarily a common view of the world. I view the departments I'm in charge of to be a huge part of the public health workforce and capacity in this city, and I think it's one that isn't always, as it should be, recognised as such. And I would say that the environmental health officers, and to a significant extent the trading standards officers, but the environmental health officers that go out every day improving the quality of people's homes, improving the quality of people's working environments, are an absolute fundamental facet of public health capacity and the public health workforce.'*

It is important, however, not to over-emphasise this difference as most of the interviewees who defined the public health system in a narrow, specialist or professionalised sense were still keen to acknowledge the important role of local government and other sectors, and most of those who described the system in a broader, outcome-focused manner still acknowledged the role of the specialist public health workforce. However, a contrast in perspectives regarding the weight interviewees placed on these different aspects of public health was clearly apparent. It was also clear that despite policy pronouncements on the broad nature of the public health workforce, the point still needed to be argued.

Relating to these tensions, interviewees also expressed some concerns about the boundaries of the 'public health system'. Several interviewees pointed out that broad definitions seemed to encompass almost everything, making it difficult to know how to focus public health activities and where to set limits to make the work manageable. However, the narrower definition was perceived by most interviewees as failing to provide adequate room for public health activities that might address the wider determinants of health. This tension is summed up in the following quotation:

NGO: *'I think we often fall into a trap of describing public health and the systems to deliver it in such broad terms that it becomes almost kind of meaningless because it's everything and nothing. And I think that's a seduction that those of us that work in the field often encounter, which is to suggest that what we're interested in and engaged with, and therefore want to have purchase on, is the* <u>*entire*</u> *system and all levers and delivery mechanisms within it. However, on the other side, I think we have a kind of policy regime which is quite reductionist and actually what it does is it kind of cuts away a lot of the big possibilities and focuses us straight onto individuals and the roles that individuals can play [in] improving their health. [...] So if you're talking about public health system I think the very terms that we use to describe it are perhaps misleading because I think it makes it very difficult to become discerning about which bit of that whole endeavour are you actually focusing on...'*

For many interviewees, the difficulties in conceptualising the 'public health system' were linked to deeper conceptual and linguistic issues concerning the term 'public health' itself. These issues are explored in the following sub-section.

**9.2 What is 'public health'?**
Relating to the various different conceptions of what public health involves, a significant number of interviewees felt that the term 'public health' was itself problematic. As the quotations in Table 9.1 illustrate, the reasons underlying some interviewees' aversion to the term related to a variety of factors but the most common concerns rested upon its links with a medical model of health and a very specialist workforce, the historical overhang of images of 19th century public health concern's with sanitation and, most of all, the varied ways in which the term was understood across different sectors and by the public:

*Table 9.1: Conceptual and terminological problems associated with 'public health'*

| Difficulties with the term 'public health' | Illustrative quotations |
|---|---|
| 'Public health' tends to denote public health specialists and a medical conception of health | DH: *'What we've found in our work here at DH is that using the terminology of public health, people often think of public health professionals, public health disciplines. We've tried to change the language that we use to the health of the public which is very much then broadening that out, particularly for non-NHS audiences. It conveys actually it's about public health in terms of individuals and their health.'*<br><br>NGO: *'We sometimes kind of imply that it [the term 'public health'] has capital 'P' capital 'H' when we're talking about the discipline of 'Public Health'...'* |
| 'Public health' has historical overhangs from the nineteenth century | NGO: *'I do think it's a problem because it's tied up with people in the public thinking either that it's disease scares and immunisation programmes or... it's like rats and drains and things like that and they don't see health and well-being... as being public health. [...] 'Public health' has been commandeered by two things; it's either been very medicalised or very environmentalised, in terms of Local Authorities' approach. And I think if we've got a confused title, we've got a confused message.'* |
| 'Public health' problematic because it is variously (and differently) understood: | PCT: *'I'm continually finding myself having to explain what it is. For example, with our new board at the PCT, I've got to do a little sort of seminar session at the next board meeting which is basically about explaining to them, our executive directors, what public health and what we do. And that's always a problem, I think, because people who are not engaged in the public health arena, the tendency of most people is to think of health issues as being personal health issues and talking about the broader health issues takes a little bit of explaining.'*<br><br>SHA: *'It's not always helpful because different people mean different things by it, and there is always the temptation of something that comes with the label public health to be considered the responsibility of the Director of Public Health. And actually the people who can probably make the biggest difference are the Chief Executives and the whole of the corporate entity of either an NHS organisation or a local authority.'* |

For some of the interviewees, particularly those working closely with central government but also some of those based in local government and PCTs, the various problems associated with the term 'public health' caused them to conclude that it was a phrase which had 'passed its shelf-life'. However, even amongst these interviewees, there was no clear consensus about a preferred alternative. Whilst some, especially

those located in central and local government, advocated 'well-being' as a more holistic and less medicalised term, others felt this was, if anything, even more fuzzy and widely misunderstood than 'public health'. A couple of interviewees were also wary that the term had been to some extent 'hi-jacked' by social care. The most common suggestion for getting over the difficulties associated with the term 'public health' was to use more precise terms, depending on the context. So, for example, there were suggestions that it might be better specifically to refer to 'health improvement', 'health inequalities' or 'health protection', as appropriate, rather than search in vain for an all-encompassing term that would more likely confuse than enlighten:

NGO: *'I think we just need to perhaps describe the element that we're talking about in much better terms rather than rolling it all up together in these two words that I don't think are always very useful.'*

SHA: *'I think it's perhaps better to not use an overarching term, but actually be specific about what it is you're talking about. [...] It's perhaps better to talk about personal health or individual health, or lifestyle risk factors, or primary prevention, rather than saying public health, because public health is a huge number of things to me.'*

For some of the interviewees, the difficulties with the term 'public health' stemmed from the way in which 'health' is often understood, by public sector workers and the broader public, as a medicalised and curative concept:

Local government: *'When people say, 'oh that's a health issue,' what they often mean - especially in local government – is, 'that's an NHS issue.' Now, the more we continue to say, 'oh that's a health issue therefore it's outside our sphere of influence,' the less we understand that health is our business. So I think part of this is about language being really important.'*

NGO: *'I think we have a problem when we use the word health, because I think health has a certain set of definitions that are attached to it. And if you ask most people what would make them healthier, or what would lead to better health, what they will tell you is that we need a lot more of the NHS-type health services. So people will quite genuinely tell you, 'if there were more doctors, people would be healthier.''*

However, there was also some resistance to losing 'public health' as a term, particularly amongst the specialist public health professionals but also amongst some of the interviewees based in local government. For these interviewees, 'public health' was a term to be used with pride. For others, the preference to keep using the term related more to a sense of weariness with frequent changes in the legitimate vocabulary, combined with a belief that changing the term would do little to address the underlying problems facing public health. For example:

PCT: *'I couldn't possibly bear it if we considered changing it. [...] I think the problem is it's a bit like how words get a set of connotations and then you change the word. It's sort of like all of the words for toilet or something, because we keep inventing a new one, because we don't really like to mention lavatory. So I think having spent many years battling with health education, health promotion, public*

*health etc that we should just stick with the word but make it mean what we want it to mean. I think battling over the terms doesn't help and people will understand what we do when we do it right.'*

SHA: *'I would be terribly opposed to any attempt to alter it. The problem is not with the term 'public health' or anyone's understanding of it, the problem is with the practice of public health, and changing the title won't make any difference.'*

Professional organisation: *'I think there are, certainly, different interpretations but I don't think that is a problem. I think it's important to stress that because I think, as an encompassing term,[...] I think that it actually has a strength to it.'*

The various perspectives on the basic phrases and concepts relating to public health, including the very term itself, point to the need for some conceptual and educative work to promote shared understandings of commonly used terms and, more ambitiously, to develop the notion of a public health system. This was remarked upon by a number of the interviewees, who felt the key to achieving desirable public health outcomes lay with the ability to instil a widespread commitment to a common vision of public health. For example:

SHA: *'I think one of the key things - and it's something that we're lacking - is a key thing for any system that's functional and that is a system that knows itself and a system that can describe itself, and I'm not sure that any of us in the public health community have put enough resources into the conceptual development of the system to be able to do that.'*

Unsurprisingly, in the light of the frequency of comments about the varied understandings of the term public health, few of the interviewees attempted to articulate what this common vision might look like. However, there was a significant degree of consensus amongst interviewees about the values which ought to underpin an effective public health system. As one respondent commented:

SHA: *'I think the values bit is absolutely crucial…values mediate how we use the evidence.'*

The most frequently mentioned of these values was a commitment to equity or fairness which several of the interviewees related directly to the need to tackle health inequalities.

DH: *'We have an obligation .... to seek the most socially excluded to reduce health inequalities and to place relatively proportionately more effort to help those groups while improving the health of the nation as a whole.'*

The second most commonly mentioned value related to the need for a public health system to be 'enabling' or 'empowering', i.e. that it should act as a system which actively engages the public and communities in health and in decision-making , rather than as a system in which public health is something that is 'done to' people.

NGO: *'So there is something, for me, that's actually quite important about a sense of individual and community empowerment over health; in other words, neither being in a position of dependency or a position of disempowerment.'*

Third, there was widespread commitment to the idea that an effective public health system would help address issues relating to social justice and social exclusion, i.e. that it would focus on wider social determinants of health as well as trying to change individuals' lifestyle behaviours. Fourth, many of the interviewees were keen to advocate the need for a public health system to be based on good evidence or intelligence not influenced by vested interests. Fifth, a number of the interviewees felt the system should reflect a public sector ethos and be publicly accountable and transparent. Other values that were mentioned include: professionalism, value-for money, respect for individual freedom, choice, a long term vision and links to environmental values.

The interviews did not specifically ask about health protection although interviewees were free to raise it as an issue in response to several of the questions asked. Quite a few mentioned health protection in their definition of public health but said little else on this domain. Two interviewees felt we ought to have specifically asked about health protection. However, one of the interviewees was keen to express their views on the subject especially in respect of the setting up of the Health Protection Agency (HPA) which they felt had been a 'mistake'. This was especially so in terms of what happened in local services where service delivery has been adversely affected as a result of the growing distance between this level and the HPA.

SHA: *They've [HPA] washed their hands of the dirty business of actually doing things to stand aside and advise and increasingly go to their corporate agenda rather than the NHS agenda.*

This respondent favoured bringing the health protection domain back not just into the NHS but where they were pre-1974. 'jointly with local authorities', a move described as making 'enormous sense'. Another interviewee commented that the HPA boundaries were often different to other boundaries which caused problems with the moves towards greater coterminosity of boundaries. A third interviewee thought that health protection would feature more prominently in the new metrics system being introduced.

NGO: *Certainly the metrics performance framework…will be consulted on. You'll see much more emphasis in that on public health, health prevention and health protection as well, which has been pretty much off the agenda in terms of government targetry of late.*

In a look at the future of health protection, the HPA's CEO claimed at the time of writing that health protection was much more in the public's eye and had a much higher media profile (Troop 2007). She believed there were implications for the continuing relevance of the Faculty's three public health domains. In particular, few public health problems in her view did not require an element of all three domains. Moreover, none of them 'really encapsulates the structural, societal or international responses that are needed if we are to make progress. Nor do they capture the multi-agency nature of the work' (ibid, p.9). Like others, her view is that a better way of

conceptualising public health, and, indeed, the public health system may be 'to consider the range of knowledge, skills and techniques that are needed – in terms of tools that apply to all aspects of public health albeit with a different emphasis in different situations'.

**9.3 Comparing the ideal public health system with what already exists**

The values considered in the previous sub-section were strongly reflected in the interviewees' various descriptions of the features of their ideal public health system. Yet, these descriptions often contrasted quite overtly with their accounts of the existing (and developing) public health system in England. In order to explore these contrasts, and gauge the extent of difference between the ideal and the reality of public health systems for our interviewees, this sub-section focuses on the key features that the data from the interviews suggest are required in order to ensure a public health system's effectiveness. These are dealt with thematically, so that for each feature we can compare how the interviewees articulated what they would ideally like to see with how they perceived the actual public health system in England. The six features, in order, are: leadership, a focus on public health outcomes, a commitment to evidence-based policy and practice, organisational issues, public health time-frames and resources, and local flexibility.

*9.3.1 Engaging with local communities*

About half the interviewees were supportive of the need to increase community development and engagement. The issue came up in response to various questions. Interviewees emphasised the key role that communities could play in galvanising action on public health issues, as long as they believed that their input would be valued. One interviewee stressed the importance of this as follows:

NGO: *'Help local communities to…become energised by the fact you're doing things in a different way and that you're acknowledging their input and you're not just telling them what to do, that they're actually telling you what to do because they've been forming national policy because of the good work they've done, then you can liberate an awful lot of good new ways of working and improvements.'*

In the same way, levers for creating an effective and proactive public health system would include, in the words of one interviewee:

PCT: *'Really working alongside people about what their perceptions, barriers, needs, wants are, and trying to create that engagement from the public, that has to be a lever.'*

Another interviewee insisted that understanding was the key to successful engagement.

Local government: *'I think you potentially could use some kind of public event approach because I think once people understand this agenda, they really engage in it. That's my experience of working with senior managers…in the Council. People become very inspired by it. There's certainly education that you need to do in order for people to understand it properly and…it's like a light bulb moment, they say "oh right, okay so the health service is only a small part of it". And health is a concept.*

*One of the things that I've noticed since working in local government is that health is assumed to be an organisation. Health as a concept is the tricky bit. So if we can get that across, I think you can inspire people…I think possibly that public seminars are the way to go.'*

A possible barrier to making effective progress was seen by at least one interviewee as the dominance of the medical model of public health. Until this particular bullet was bitten, it was unlikely that genuine or sustained public engagement would be forthcoming.

DH: *'Well I feel very strongly that we should dump the medical model of public health and that we should replace it with a community engagement model. I think the medical model's been shown to fail. And the basic premise is that if you tell people what the right thing to do is, that they'll do it, is kind of patently untrue.[…]And the most successful programme of improvements in understanding and well-being in health which I know of are projects like [Blank – local project], which are really driven by community development style work and are about starting where people are in the community working with particular ethnic groups, working with temples and mosques and faith groups at various times, community groups, schools, employers. And although they have input from public health physicians and others, they are not medically 'led'.*

Issues related to public involvement in decision-making are discussed in sub-section 10.3 below.


*9.3.2 Leadership*

The need for effective leadership within a public health system was articulated by a narrow majority of the interviewees. Yet, despite widespread agreement that this was a central feature of an effective system, many of the interviewees expressed disappointment at the limited leadership within England's current public health system, at both national and local levels:

DH: *'There are issues around local leadership and particularly around the political leadership of local government and the strength of the NHS leadership locally and how you get that balance right […] You've got those barriers.'*

SHA: *'I think we've lacked public health leadership. Public health got too focused on standards of practice and all sorts of inward-looking things… Big changes to the health of the public and the determinants of the health of the public have been floating past its window, and all it's been really focused on are the standards of public health practice, and it's really missed the point.'*

NGO: *'I would say that's possibly, in the past, been one of the great weaknesses of public health systems – just not enough clear leadership. And particularly leadership right across the whole system, rather than just leadership of individual performance of the system.'*

The absence of leadership has become a familiar refrain and yet there appears to be a dearth of effective programmes aimed at remedying this deficit. Maybe the reasons

lie in McAreavey, Alimo-Metcalfe and Connelly's (2001: 460) view that 'further work is required to delineate what 'effective' public health leadership means both in relation to 'transformational' leadership characteristics […] and in relation to training and continuous professional development requirements'. However, over time a clearer idea of what skills and attributes public health leaders require has emerged (Hunter 2007).

The Department of Health has commissioned a scoping review of future leadership needs which will consider whether the limited existing national public health leadership programmes, together with other more recent programmes, are sufficient or require additional investment.  The architects of one such programme assert that effective leadership for health requires

- building whole system relationships
- understanding and using improvement methods
- developing exceptional leadership skills to move these areas forward (Hannaway, Hunter and Plsek 2007).

The absence of leadership is a problem throughout the public health system from the top down and has been remarked upon by many commentators. In his review of public health in 2004, Wanless (2004) drew attention to the evidence of poor leadership and management skills.  As we noted at the outset of Part 2, the Department of Health has been criticised for weak leadership in its capability review (Cabinet Office 2007), and those working in public health are aware of the problem.  For example, Gabriel Scally, RDPH for the NHS South West, raises the issue in his 'expert paper' prepared as background for Blair's 2006 lecture mentioned earlier: http://www.number-10.gov.uk/output/Page9914.asp.


*9.3.3 A focus on shared values, and goals*

In order for leadership to work effectively within a public health system, another commonly noted necessity was the existence of clear and widely shared goals, a common vision, reflected in a focus on outcomes.  For many of the interviewees, this also required an effective performance management system to be in place alongside a clear agreement about the roles and responsibilities of the various component parts of the system:

PCT: *'There needs to be common agreement about the aims of the system, about the goals.  There needs to be effective communication between different players.  [...] As well as there being common agreement about their goals, the goals need to be clear rather than woolly and there needs to be some performance management of it all.'*

SHA: *'I would say that the hallmarks of any system are that it's got a particular set of goals that are the same across the different partners.  So the system will have a vision, an aspiration of where it wants to get to.  It would have a strategy of how it's going to get towards that aspiration.  Within that strategy there are likely to be a combination of goals or objectives which are set with a timescale and therefore there are milestones of progress.  That implies that there's a way of measuring something and so it would have to be something that can be measured.'*

PCT: *'Well, what I would like to develop in [this city] is a single public health function for the city that incorporates elements of the local authority and the PCT, the NHS and the voluntary and community sector and the local NHS providers and so on so that, in five years' time, there are loads of people working in public health in the city, some of whom are employed by one organisation, some are employed by another organisation but with clear aims, clear objectives, performance managed as a coherent enterprise.'*

The establishment of shared goals, targets and performance management systems was seen by many of the interviewees as a key change which would encourage effective partnership working (see sub-section 9.3.2). And, as the notion that working in partnership was crucial for achieving public health objectives was widely supported by interviewees (see sub-section 10.2), it is not surprising that many of them suggested that this was an area which they would like to see policy-makers tackle in the near future.

Interviewees' desire for shared goals and targets further underlines the demand (highlighted above) for some conceptual work around the development of a public health system. The hope, expressed by many of the interviewees, is that, if a shared understanding of the values and dimensions of a public health system could be achieved across all relevant sectors, then public health policies and activities would benefit from a new sense of coherence and, furthermore, public health problems could be tackled with truly multifaceted approaches. However, as both this sub-section and sub-section 9.4 attest, aspirations towards the 'mainstreaming' of public health in this way contrasts significantly with interviewees' accounts of the current, disjointed reality.

### 9.3.4 Evidence-based policy and practice

For a public health system to be truly effective, several interviewees suggested that policies, targets and interventions ought to be more closely based on the available evidence and information, both at a local and national level. For example:

NGO: *'[An effective PHS is] a system that's using information and evidence, [...] one that's making commissioning decisions based on effective evidence, cost effective evidence, is using good central robust indicators to monitor progress and so on. I think another feature that's really important that it's a system that doesn't sit in isolation. I mean the danger with public health always is that it's seen as a slightly marginal add on to what core business in the NHS is. It's got to be absolutely central to the decisions that Primary Care Trusts and other organisations are making about the services and care that they commission.*

PCT: *'One critical thing that underpins all of this, of course, is good, effective information systems and being able to analyse and understand the health needs of populations at a local level, because without that, you can't create the arguments that will persuade people to change what they're doing.'*

The effective supply and use of information and evidence was seen by several interviewees to be particularly important in the light of recent moves to encourage

joint commissioning for health and well-being. These issues are therefore discussed further in sub-section 10.1, which focuses on the commissioning agenda.

### 9.3.5 Organisational issues

As already discussed, many of the interviewees, including some based in the NHS, felt the current 'public health system' was too heavily associated with the NHS and that this often resulted in too narrow a conception of what a public health system involved:

PCT: *'I suppose really the Public Health System, as it's currently constituted, is still very NHS orientated, or if we really push the boat out we think about local authorities, but we don't think about the whole social and civil environment, and in that sense it isn't a public health system.'*

SHA: *'Public health is a broadly shared social aspiration and outcome, but we still have a narrowly focused NHS/Department of Health managed, professional system trying to manage it.'*

Professional organisation: *'I think it [the current public health system] is largely medically-orientated and I think public health is wider than the medical model, and I think [...] we're putting resources into an illness system that tends to overshadow the public health infrastructure that is there and gives too much emphasis to the curative sides of public health intervention when really we ought to be, as Wanless says, actually getting on the preventative side far more.'*

Views on how to overcome the problem varied between interviewees. Some felt a greater focus on the role of local government in addressing public health concerns, in line with recent developments, would provide the required counter-balance to NHS focused activities. However, several interviewees felt more significant organisational changes were required if England was to achieve an effective public health system. As illustrated in the quotation below, suggestions were sometimes based on developing a new, and more autonomous, 'public health system' rather than promoting connections across agencies which form the elements of a public health system:

SHA: *'I think that we should give some serious consideration to actually developing a public health system. And you might think of it as a health improvement system or a health equality system, which is outside of, or encompasses the rest of the Health Service. So rather than thinking it is a branch of the Health Service or a strand of Health Service work, where it will always suffer from low funding because it's generally not acute - and acute, urgent, immediate things require funding immediately and they'll take all the money - what we should be thinking about is either a separate stream of funding for health improvement in dealing with inequalities, or we should be thinking about a public health system which is independent of secondary and primary care provision. So perhaps an overarching body within the Department of Health, or you could have it as a completely separate structure which is linked to both the NHS and local government, through which funding streams for the two could be brought together.'*

SHA [different interviewee to above]: *'I would like a formal fundamental review of public health systems in the country, involving all of the stakeholders, so particularly public involvement, county councils and local authorities, and probably not led by the NHS because that would give it too much of an NHS focus. And I would like to see it develop into a Department of Health based, public health structure, maybe a beefed up Chief Medical Officer's office with a hierarchical and performance managed structure beneath that, which had its own funding streams – so it's not subject to raiding by local NHS, or by local government executives – and a defined budget for public health and a defined series of expectations and objectives which were properly performance managed and monitored.'*

NGO: *'I think it would benefit public health if it could occupy a slightly more autonomous position in local public service economies. So whether that's a separate unit, or an arms length unit, or you know, a bit like what local government have done with housing, it becomes an arm's length management organisation and it's given a default budget from local government and primary care trusts, and can then get on to configuring and commissioning its own services. I think that would be a fantastic step forward for public health.'*

That said, from the perspective of those working in the NHS, there was also a significant amount of wariness about any kind of further NHS reorganisation, following the frequent reorganisations that the NHS has undergone in recent years. Whilst most of the interviewees were supportive of recent reorganisations designed to achieve coterminosity of boundaries between local/central government and NHS bodies, there was a clear sense of fatigue in relation to the raft of changes experienced in the past 10 years. For example:

PCT: *'I don't want any more changes. I mean [...] in a way we can almost work with any system, but it takes a bit of time to recover from the turmoil of one system change, and then learn how to work it [...] Because with every change there's all the gaming that goes on and people ... don't want to start anything because they can't be sure that they'll be able to finish it. So organisation stability please, please, please, please, please.'*

PCT [different interviewee to above]: *'I think a bit of stability would be extremely useful, to be frank.'*

PCT [different interviewee to above]: *'I think what we now need is a bit of stability. You know, we could always do with more resources, but, overall, the most important thing is a bit of stability and being allowed to get on and do the job and deliver.'*

Many NHS interviewees felt that the structural changes had impacted negatively on their ability to make long term plans, to form relationships with others and, often, to focus on much else other than fitting in and staking out a place within the new organisational structures. None of the interviewees seemed to feel that promoting the health of the public was a key concern for the architects of successive NHS reorganisations, and several suggested that questions of how public health activities would be organised was often a casualty, or an 'after-thought':

PCT: *'I think the constant changes don't help really because it's very difficult to design a system which works when you're constantly changing every level of the NHS and constantly reorganising locally as well. So that's always a challenge really. And, we don't make it any easier for ourselves when the paradigms shift every couple of years or whatever.'*

PCT [different interviewee to above]: *'It feels as if … public health is really the afterthought to the reorganisation that's taken place.'*

For those based in local government, the constant reorganisations of the NHS seemed baffling and interfered with the incentives designed to promote collaborative working. For several interviewees, this issue provided further support for the notion that public health would be 'safer' and more effective if the core responsibilities were transferred to local government. If nothing else, it would offer a degree of protection from constant central government interference and meddling. For example:

SHA: *'I mean one of the gripes of the local authorities is that we work very hard on partnership working and then the NHS decides to reorganise itself after two years and we have to start all over again. We're getting close to the end of the road with that now – I think another reorganisation might just be the straw that breaks the camel's back. Local authorities are just fed up with having to work with the turmoil in the NHS and feel that they'd probably do a better job on their own, so we have to show that we can add value there.'*

The recent capability review (Cabinet Office 2007) comments on the degree of detachment from key stakeholders of the Department of Health. In his 2006 annual report, the Chief Medical Officer acknowledges 'the need for the public health profession to employ novel strategies in cross-governmental working' – a need that he concedes has never been higher and for which additional resources will be required (Department of Health 2007b: 12). But the suggestion that the NHS should relinquish its leadership role, or share it on more equal terms with others is not one that appears to have been officially acknowledged. Nevertheless, it may be of significance that, in the recent restructuring of organisational arrangements relating to the NHS within the Department of Health, a new post of medical director has been created. Significantly, the post-holder is directly accountable to the NHS CEO, not to the CMO, and will take over responsibility for issues to do with patient safety and quality of service, leaving the CMO to focus more specifically on the wider public health function, including health inequalities and health protection (*Health Service Journal* 2007).

This move is significant in that, whether intentional or not, it in effect acknowledges that locating the three domains of public health – health promotion, health protection, health service improvement – under a single individual may no longer be workable and that, in future, these responsibilities, especially those relating to health service improvement, may need to be split. Indeed, such arguments were advanced in a report produced by three major organisations – Local Government Association, UK Public Health Association and the NHS Confederation – in response to the *Choosing Health* consultation exercise (Local Government Association, UKPHA, NHS Confederation 2004). The authors were keen to maximise the CMO's influence on public health but considered that the current remit of the CMO 'is too broad, covering as it does the domains of health improvement, health protection and healthcare

quality. The breadth of the role is a serious barrier to the post being effective in securing better public health' (ibid: 13). The report suggested that reducing the CMO's 'job stretch' would allow him (or her) to become 'a stronger advocate for preventive interventions' and to prioritise this agenda among senior policy-makers and practitioners. Some of the interviewees involved in this review raised similar concerns, especially in regard to the need for stronger public health leadership (see above, sub-section 9.3.2).

Joining in the debate on this issue, in its recent consultation paper on public health, the Conservative Party states that it wishes to see the CMO's Department strengthened and for the CMO to be divested of responsibilities for exercising leadership within the medical profession with respect to regulation, education and training in order that s/he might focus on improving public health outcomes (Conservative Research Department 2007). The consultation document suggests that the 'wide range' of the CMO's current functions 'brings into question the desirability of continuing his role unchanged' (ibid: 15).

### 9.3.6 Public health timeframes and resources

Relating to some extent to the incoherence of national policies, many of the interviewees felt the current resources allocated to public health were insufficient to achieve the desired (or even expected) outcomes. A significant number of interviewees reported that public health budgets were frequently raided for other NHS activities due to that fact that clinical and financial targets were often seen as more important than public health targets. As our interviewees testified, the limited resources available had prevented broader and more radical approaches to public health from being adopted:

PCT: *'We [the PCT] started getting into very severe financial difficulties in [Blank – city] in 2005/6 and then again 2006/2007 so when people left [public health], they weren't being replaced. And, obviously, public health being one part of the PCT's spend that they were able to control very immediately, it was immediately seen as a place for making savings.'*

NGO: *'None of the money that's promised for public health has seen itself through. You know, it's ridiculous that services like smoking cessation are being cut at a time when you need greater investment in them. I mean it's an absolute scandal. People are leaving the profession. The cuts are big and have been throughout the system'*

The failure of many PCTs to direct *Choosing Health* monies to public health activities, and the failure of central government to prevent this was one key example that interviews cited of the low priority attached to public health. Even though this money was supposed to have been used by PCTs to fund public health activities in their areas, only one DPH reported that all of the allocated money had been spent on public health activity. Other DsPH reported either that they had received virtually none of this money to spend on public health activities, or that a significant amount had been used to fund other aspects of the health system. The statements of these DsPH, some of which are reproduced below, were also reflected in the overviews of many of the RDsPH as well as in the anecdotal accounts of interviewees based in other sectors. As well as illustrating this point, the first quotation below illustrates

how some of the interviewees felt the problems around funding had damaged some of the fragile partnerships that recent policy initiatives have sought to encourage:

PCT: *'Well I think one of the downsides is funding […] and that seems to take precedence over everything, to be frank, so we are in a very difficult financial situation, coupled with having to hand money back to help other parts of the country, which is making things even worse. So even with* Choosing Health *money, our Director of Finance just sees it as a free good to help out a deficit. And if you're trying to make change, if you're stimulating the third sector, trying to work with others, then you need funding somewhere along the line. And getting it swiped, or attempting to be swiped, just does not help. And I think it's very disappointing, because on the one hand, the Government have tried to give a commitment with* Choosing Health*, that public health's important and has put in new funding, but it has then allowed, or seems happy for it to be taken away again. It's a really odd way of working.'*

PCT [different interviewee to above]: *'We should have got £3.2m recurrently for public health – in fact, we were able to use about, somewhere between £400,000 and £500,000 specifically on [public health issues] but the rest of it got lost in our financial black hole. It went to support the PCT's underlying financial deficit. And one of the things that I think I have to do is to make the case for getting that money back into public health. So we lost most of it because it was not ring-fenced.'*

DH: *'I was very sad that* Choosing Health *monies were diverted so rapidly, and I think the effect on the sexual health service has been devastating ...and it isn't good enough really for a state to say "well these are the choices made locally and they should have put the money into these services because it's what it was provided for" but at the same time we were saying, 'don't overspend'. It was free unattached money so I feel badly about that.'*

Even interviewees based in the Department of Health expressed clear concerns about the funding of public health in recent years. In addition to the above interviewee, who spoke of his/her regret at the way *Choosing Health* monies had been distributed, the following interviewee (a different individual), suggested that funding restrictions were not only an issue for public health at the local level but also posed problems for public health activities within central government:

DH: *'Health prevention has been pretty much seen as a Cinderella service. In DH, it's the smallest bit, has been the smallest bit of DH, and very much out there in the field. All the stories that if funding started to be cut, what went first - well it was all the prevention stuff, wasn't it, that went first?'*

The interviewees' concerns are endorsed by the CMO in his annual reports for 2005 and 2006 (Department of Health 2006 and 2007b). In his 2006 report, the CMO calls for support to be given to public health professionals to enable them to perform the 'difficult job they are doing' in circumstances when 'the actions and activities necessary to achieve improvement in the population's health are often complex and work over the long term' (Department of Health 2007b: 5). The CMO is especially anxious to ensure that the resources necessary to do the job are available. Recalling his concern in his 2005 report over the 'dangerous practice of raiding public health

budgets to prop up hospitals with financial problems', his most recent annual report outlines that he hopes that public health budgets can be restored now that the NHS's finances are in surplus. This is against a context in which obesity rates have reached an all-time high, a trend of significance to patterns of health inequality, and there is a growing threat of crises relating to globally transmitted infectious diseases. To emphasise he means business, the CMO warns that if evidence of raids on public health monies is brought to his attention, he 'will not hesitate to draw attention to them' (ibid: 12), although the report stops short of suggesting any action against guilty PCTs. For many of the interviewees, and despite the CMO's concern and warnings, the failure to ring-fence the *Choosing Health* monies specifically for public health activities underlined the limited nature of central government's commitment to addressing public health.

Whilst, in an ideal world, virtually all of the interviewees would like to see more funding directed towards public health activities, most were realistic that financial resources were always going to be constrained. However, the shortage of funding for public health was not the only problem interviewees articulated; perhaps more important for many was the short-term nature of public health policy and planning and the similarly short-term nature of the funding schemes accompanying these policies:

DH [different interviewee to above]: *'One of the things I've come late to understand in my move across the public sectors from local government to health was just how non-strategic central government is. Their timeframes are very short-term. They don't think in terms of long-term, and you see fairly abrupt shifts in policy over 18 months or two years or even shorter periods.'*

PCT: *'We're still very dependent, partnership working's still dependent on the short term money so we're constantly using Neighbourhood Renewal or whatever for partnership working. And we never really, we don't mainstream a lot of what are called public health initiatives really. [...] The ones that would suffer most [if funding reduced] would be the lifestyle - if we don't get funding it'll be a lot of the work around smoking, alcohol, obesity that will suffer.'*

As many of the interviewees viewed public health as an activity, or a set of aims, which were, by their very nature, focused on long-term issues, the short-term nature of much central government policy was a key problem that a more effective public health system would need to confront and seek to overcome. Ideas about how this might be achieved were, however, rather thin on the ground as most of the interviewees were realistic about the political (election-based) drivers of policy-making at this level.

*9.3.7 Local flexibility*

The final dimension of a desirable public health system which emerged as a key issue in the interview data was the importance of the need for local flexibility in dealing with public health issues. Perhaps reinforced by the frustrations, outlined above, about central government's short-term outlook, but more overtly triggered by concerns with nationally enforced targets, several of the interviewees were keen to highlight the importance of having a public health system which could be adapted at a local level to meet the specific needs of different communities:

SHA: *'I think it has to be integrated with a number of other systems, with government processes, with the NHS, and with local government and voluntary and community sector services.  It would have to be comprehensive.  It would have to be flexible enough to deal with the different health needs of different communities.'*

NGO: *'Local freedom to do things is absolutely critical in public health because when I've seen good examples of how things work it's because they've emerged that way, not because somebody said, this what you've got to do.'*

SHA [different to interviewee above]: *'I think the most important things that could happen would be the devolution of power and resources to public health systems locally.'*

It is unclear how the desire, expressed by many of the interviewees, for more coherent and joined-up goals, targets and performance management systems (see above, sub-section 9.3.3) sits alongside these calls for a system with room for increased flexibility at local level.  At first glance, the two aspirations seem to conflict, although one way of overcoming the tension might be for all relevant sectors in local areas to agree on local goals and targets, within the context of national guidance, and then to be performance managed on an area, rather than sectoral, basis.  The reward element of LAAs already provides incentives for such an approach. Some interviewees seemed hopeful that this might indeed be the direction in which public health policy is moving.

## 9.4 Policy connectivity and coherence

One of the key problems that interviewees articulated in relation to the current public health system involved the lack of connectivity between its different component parts. The lack of joined-up working appears to be evident at a variety of levels of the system, from the absence of policy coherence at central government level, to the difficulty of ensuring all the necessary parties are actively involved in public health activities at local level:

SHA: *'I would probably question the notion that there is actually a public health system.  I think we have public health components of a number of different other systems and that might be part of the problem really. [...] I think the system has developed in a rather chaotic way [...] and I think the pattern is very different in different parts of the country.  I worked in [one region] before, and I've come to [another region] and I've found that the culture and the way of doing things, the priorities, are all completely different.'*

NGO: *'We just have not got the right people at the table yet in terms of public health systems.  And I would particularly cite people like ... planners, people who design transport systems, local government responsibility for spatial planning.  I think in some areas there are bits of economic planning and economic regeneration, [which] are aware of health and the issues but they're not at the table.'*

NGO [different interviewee to above]: *'I think very often what we have, at the moment, is a public health delivery system which is quite fragmented because there's stuff being focused on individuals and encouraging individuals to behave differently*

*and to make different kinds of choices [...] but then you have a whole set of national policies that seem to be working in the opposite direction.'*

A significant number of the interviewees felt the lack of connectivity had resulted in direct tensions within the raft of various recent policy initiatives. For example, several interviewees felt there was a tension between commissioning for health and well-being, on the one hand, and practice-based commissioning on the other. The other major policy conflict on which interviewees focused, which is discussed further in sub-section 11.1, was that between the incentives to increase choice, on the one hand, and the government's existing commitments to reducing health inequalities on the other. Further policy conflicts which a smaller number of interviewees mentioned included: the government's approach to alcohol (especially the relaxation of licensing hours) compared to its public health commitment to reduce excessive alcohol consumption; the three percent productivity requirement being placed on local authorities, which one interviewee thought would conflict with recent attempts to encourage local authorities to play more of a role in public health; the decision to make commitments to particular programmes, such as child centred health, even though key sections of the relevant workforce, such as health visitors, had been allowed to decline. There was also an issue over how best to prioritise across the three domains of public health described by the Faculty of Public Health.

The number of potential conflicts between various policy commitments referred to above paints a picture in which, as the following interviewee suggests, it is likely to be difficult for public health professionals to ascertain precisely what their foci should be, or predict how the complex array of recent policy initiatives is likely to unfold and impact on their work:

SHA: *'There are a number of different policy initiatives which potentially conflict. For example we've got the drive to reduce inequalities but the drive to improve choice, and they're in direct competition sometimes. Then we've got this strategic commissioning role of PCTs, but then at the same time more locally deterministic commissioning by practice-based commissioners. And then we have a whole range of models of practice-based commissioning emerging, and in some areas GPs are being very innovative, very entrepreneurial, and in other areas they're not interested at all, and so we're getting a very patchy landscape of how things are going. And it's hard to pull all of that together into a sort of coherent model for a patch, so it's quite difficult to see where it's going to at times.'*

The widespread criticisms within the data of the lack of policy coherence emanating from the Department of Health receive support and confirmation in the Cabinet Office capability review described above (Cabinet Office 2007). They were also evident in the findings of a study exploring what incentives exist for NHS managers to focus on the wider health issues conducted for the King's Fund by Hunter and Marks (2005). It almost goes without saying that in the ideal public health system articulated by most of the interviewees for this scoping study, national policy would be shaped and co-ordinated in a manner which ensured that public health issues were consistently prioritised across departments. Furthermore, public health values and goals would be mainstreamed to the extent that a broad and diffuse workforce would either all have some knowledge of the need to focus on public health outcomes or, at the very least,

would be encouraged to work in ways which would contribute to, and promote, better public health outcomes.

In addition to providing a context in which public health objectives were more likely to be achievable, several of the interviewees who focused on the need for greater policy coherence suggested that this issue was linked to the ability to create a public health system which was able effectively to grapple with wider social and economic determinants of health (see Section 8). If public health values could be mainstreamed, the hope, to quote one of the following interviewees, was that broader (non-health) policies, at the local and national level, could be 'public health proofed':

NGO: *'I think there has to be a revisiting of some of those fundamental policy commitments of the past ten years, so you have to do something about child poverty. We have to do something about making it worthwhile for people to work. I think what we need to do is kind of public health-proof, if you like, a lot of other policies that actually have a direct impact.'*

DH: *'I would like to put public health into local authorities and into libraries and into transport policy and… I would want to say that every local authority should have a public health impact assessment on its transport policy. And I would like them to make using cars much more difficult. I'd like them to make using bicycles and walking much easier. I'd like them to design the roads and the community facilities so that pedestrians have priority over vehicles. You know, all these things. I'd like us to be much more rigorous with the manufacturers of foods, so that instead of them just sort of promising to do better about reducing salt and fat and sugar that they actually had to do better.'*

SHA: *'I think we've got to keep a focus on public health being part of the mainstream agenda, and people's health being part of the mainstream agenda. I don't want to see it separated off. I want to see it kept solidly in the mainstreams so that any board of a NHS organisation, any cabinet within a local authority, knows they've got the responsibility to deliver improvement in health as well as to deliver good services.'*

The mainstreaming of public health goals to this extent presupposes that shared public health outcomes and goals can be achieved even though, as sub-section 9.3.3 discussed, many of the interviewees did not feel this was currently the case.

## 9.5 Progress in public health

The issues raised in sub-sections 9.3 and 9.4 paint rather a negative picture of the current public health system in England and it is indeed the case that many of the interviewees seemed somewhat depressed and frustrated by the existing situation. Some even felt that current arrangements were so incoherent that they could not reasonably be described as a 'system'. However, there were also some positive reflections on recent developments. Interviewees who had worked in systems outside the UK were particularly enthusiastic about the advantages and benefits of the English system. For others, whilst they clearly felt there were significant drawbacks with current arrangements, they were also keen to point out that recent years had seen some extremely positive advances. For example:

NGO: *'I can see huge benefits and things that have happened locally with the smoking cessation campaigns and a real sustained emphasis on the healthy schools agenda, that kind of thing. So there are lots of positive things I could point to.'*

One policy development which was widely supported by interviewees was the move to strengthen the multi-disciplinary nature of public health and to promote partnership working. These developments are discussed further in the following section but it is important to highlight that one of the recent changes most frequently commented upon in a positive light was the way in which interviewees felt public health had risen up the agenda of local government:

PCT: *'Something's happened to raise health and well-being issues a long way up the agenda of Local Authorities. They're interested in it in a way that they just weren't certainly not ten years ago and they were only beginning to be interested in it five years ago. I don't know exactly what it is that's suddenly put it right on their agenda but there's been some change.'*

DH: *'I've been very impressed actually in the last six months or so by the enthusiasm of a lot of local authorities for really biting into health improvement.'*

There was also quite widespread support for some recent organisational developments, notably the coterminosity of boundaries, and the introduction of jointly appointed DPH posts (also discussed in a later section). Additionally, there was some sense of pride in the commitment of many of those actively involved in public health.

Returning to organisational matters, as already discussed, several interviewees were optimistic that forthcoming changes to the performance assessment systems would result in a closer coordination between the systems used to manage local government and those applied to PCTs. Setting aside the claims of some of the interviewees that public health responsibilities ought to be moved out of the NHS and into local government (or, at a central level, taken out of the Department of Health), there was some evidence that interviewees were relatively happy with current organisational arrangements and there was certainly a clear desire not to have to deal with any further reorganisation in the near future.

In fact, it is essential to highlight that in articulating the difficulties facing England's developing public health system, and the disconnect between interviewees' perceptions of this system as compared to what they would ideally like to see in place, nearly all of the interviewees were wary of further 'tinkering' with present organisational arrangements. Perhaps this is only an understandable and legitimate human response to the 'shock and awe' elements of recent reforms and the manner both of their announcement and subsequent implementation, both of which have done much to alienate staff and lower morale (see sub-section 12.2). Nevertheless, the kinds of changes, if any, that interviewees seemed to desire related less to those of a structural and organisational nature and more to the need for some conceptual work to develop a more coherent and consensual view of how a public health system would operate, as already mentioned.

Our interviewees made few references to incentives, and whether those which did exist were appropriate and having an impact. Although there are targets to be met in

respect of life expectancy, child obesity and inequality these did not figure prominently as being especially problematic. The difficulty was in meeting them given all the other pressures and contradictions arising from the general policy context and recent organisational changes. Indeed, the message to emerge echoes that in an earlier study of incentives undertaken by two of us. It is that, despite all the talk of public health being a priority and of partnerships being important, there remains a serious absence of commitment to making progress on these objectives (Hunter and Marks 2005). In the earlier study, there were also mixed views about the value or relevance of targets as conceived and a need to consider a new approach. But overall, the difficulty was seen to be less a technical one and more a political one.

## 10. Impact on the Organisation and Management of the Public Health System of Arrangements for Commissioning, Partnership Working, and Public Involvement

In this section, we explore the impact on the public health system as we have described it (see Part 1, Sections 2 and 3) of a number of key components arising from the prevailing policy context. These are regarded as vital for an effective functioning system, and for the successful implementation of government policy objectives to improve health and tackle health inequalities. We focus on three such components:

- commissioning for health and well-being (sub-section 10.1)
- partnership working (sub-section 10.2)
- public involvement (sub-section 10.3).

As this section illustrates, interviewees' comments suggest that the implementation of each of these objectives is shaped, and often constrained, by the limitations of the current public health system, as discussed in Section 9. Of these three components, commissioning is clearly the overriding objective, since partnership working and public involvement may be regarded as key elements of an effective commissioning framework as set out by the Department of Health in its consultative document (Department of Health 2006).

Cognisant of deep-seated weaknesses in the commissioning function from earlier reforms, especially in respect of public health and health improvement, the government has now sought to identify the weaknesses and possible remedies to seeking to strengthen capacity and capability to ensure the commissioning function is effectively discharged. The culmination of these efforts is the *Commissioning Framework for Health and Well-being* which has been widely consulted upon (Department of Health 2007e). In October 2007, the Department of Health launched its World Class Commissioning initiative, *Adding Life to Years and Years to Life*, which is intended 'to have a profound effect on population health, reducing health inequalities and ensuring people live longer and healthier lives' (Britnell 2007). The consultation document mentioned above asserts that the framework is 'about action, with a particular focus on partnerships' (ibid: 7). It accepts that there is currently too much of a focus on treating illness rather than preventing it and also acknowledges the wide-ranging nature of the task in building sustainable communities, which must

include work around broader determinants of health such as employment and housing as well as health and social care services.

The framework identifies eight key steps to more effective commissioning:

- putting people at the centre of commissioning
- understanding the needs of populations and individuals
- sharing and using information more effectively
- assuring high quality providers for all services
- recognising the interdependence between work, health and well-being
- developing incentives for commissioning for health and well-being
- making it happen – local accountability
- making it happen – capability and leadership.

A core theme of the commissioning framework is partnership – both partnership at local level between the NHS, local government and third sector; and partnership between the public and commissioners. Our interviewees' views on each of these are reported later in this section. The theme of partnership is also picked up in the local government white paper, *Strong and Prosperous Communities* (Department for Communities and Local Government 2006). It proposes greater collaboration between health and local government in which joint commissioning is a key feature. Joint commissioning already exists in respect of children's services and may therefore have a wider relevance to promoting health and well-being. Joint commissioning is expected to proceed via a joint strategic needs assessment as set out in Annex A of the consultative commissioning framework. It is believed to be 'the only firm foundation for commissioning decisions and investment' (Department of Health 2007d: 24).

As part of efforts to strengthen commissioning from its currently weak base, the consultation document is also concerned with ensuring that issues of capability and leadership are addressed. As noted in sub-section 9.3.2, these issues are both seen to be key weaknesses in the present system and, unless they are addressed, then commissioning is likely also to remain weak.

Against this policy backdrop, we discuss interviewees' views on commissioning for health and well-being (sub-section 10.1), partnership working (sub-section 10.2) and public involvement (sub-section 10.3).

**10.1 Commissioning for health and well-being**

Several of the interviewees had difficulties with the basic concept of 'commissioning for health and wellbeing'. For them, commissioning was an activity which they associated with the provision of health care services and therefore not one which they felt particularly comfortable with using in relation to what they saw as an activity primarily relating to preventative action. In the context of PCTs, this conclusion seems surprising and out of kilter with their core business, which is to assess and meet the health needs of their populations, although, as illustrated below, it may simply reflect the fact that factors influencing the broader determinants of health and well-being cannot be 'purchased' in a straightforward manner. As the following quotations illustrate, there was a level of resistance to applying the term 'commissioning' to any aspects of public health:

NGO: *'I don't like commissioning. Who's commissioning? […] How do you commission for [public health], other than commissioning a whole load of health trainers or health promoters or doctors that get a bit more in their contract for doing a bit more blood pressure? […] It's very difficult to understand how you're moving into a new terminology if you're using the old terminology; it's tacked on to old terminology like commissioning, which is a totally NHS based activity. […] The mere language is exclusive. Can you imagine a person in the voluntary sector sat around a table at the local authority or LSP […] hearing about commissioning? I mean it just sounds so professional and experty.'*

NGO [different interviewee to above]: *'One of the things that people like to talk about now is commissioning for health improvement. Well, you might want to ask the question whether it's a fundamental dichotomy between the word "commissioning" and the word "health improvement", you know? Do we not improve health by other means, other than by using the same means that we commissioned maternity services or that we commissioned GP services through? So there is a problem with the definition.'*

PCT: *'We're still, I think, very hooked up on the secondary care agenda, even though it's changing a bit, and commissioning is still very secondary care focused really.'*

One aspect of joint commissioning which seemed to be welcomed by most of the interviewees was the role it was seen to play in promoting collaborative working, particularly between PCTs and local authorities. For example:

PCT: *'I think it [joint commissioning] is forcing stronger partnership working, and I think that's very good. So I do think we're on the right direction.'*

Additionally, as the next quotation illustrates, some of the interviewees felt that joint commissioning was contributing to improving local flexibility in public health decision-making, an aspiration which was also widely supported amongst interviewees (see sub-section 9.3.6):

NGO: *'I think the notion that somehow you can rearrange the pieces locally and you can invest and disinvest according to what is needed, and you have some local latitude over what the priorities are and how things can be done and structured, then I think that, in essence, is a good thing.'*

Overall, however, there were only a handful of unqualified statements of support for joint commissioning contained within the interview data. This is perhaps not surprising, in one sense, given that the agenda is a new one and has consequently not yet fully developed or had a chance to bed down. More worryingly, especially in the light of the commissioning framework described earlier, the data also reveal a lack of clarity about what commissioning involves and a concern about the limited guidance provided to local bodies. These concerns are articulated most clearly by the following interviewee, a Director of Public Health, but are evident in less overt ways in the transcripts of practitioners situated in a range of professional locations:

PCT: *'I have a feeling that there's this perplexity around joint commissioning, what does it mean? How are we going to do it? Never mind how are we going to do it in a*

*way that addresses the choice agenda at the same time? So I'm so worried that the complexity of both of those tasks is significant, I'm sure we will work through them, but it's quite a tight timescale so we need to show really good progress quite quickly, and yet I'm not sure there are models to borrow from.'*

Several factors were perceived by significant numbers of interviewees as central to the success of commissioning for public health. Four in particular merit further comment: the development of a workforce equipped with the requisite skills, the provision of sufficient resources, the achievement of more effective collaborative working, and the provision of a coherent and supportive policy context. Additional factors which were perceived as important by a smaller number of interviewees include: the use of available evidence in making decisions about commissioning, organisational and policy stability, and increased public awareness of public health aims and involvement in commissioning. Each of these factors is briefly discussed in turn.

*10.1.1 The development of a workforce equipped with the requisite skills*

Bearing in mind that commissioning for health and well-being is a relatively recent policy initiative, it is not surprising that many of the skills required for it have not formed part of public health specialists' training to date. Several interviewees felt the lack of skills posed a threat to the potential success of the commissioning agenda, as the following quotations illustrate:

NGO: *'I think there's still an awful lot to be done to get public health professionals more engaged in the commissioning agenda and understanding the skills that are required there to bring about change.'*

PCT: *'Commissioning did not go well at all [in this area] ... and the reason for that was, certainly here, we're up against the might of hospital trusts and becoming smaller PCTs with, in fact, less skilled people, we weren't effective at all.'*

NGO: *'One of the problems is there's a lack of commissioning experience in the public health community. We found this when recruiting Directors of Public Health. We couldn't find enough individuals who are really good at this, even for the NHS side of things. To find those who have got any experience of commissioning, more broadly, in social care environments, for example, is very rare. And so we've got a workforce which may not have all the skills it needs to deliver on this agenda.'*

Several of the interviewees based in the Department of Health accepted that a lack of capacity and skills were problems which the commissioning agenda, and public health more generally, faced. However, they were, overall, more optimistic than many of the other interviewees that current and planned investments in training and capacity would overcome these difficulties. Some of the interviewees based in public health specialist posts saw the problem of a lack of skills relating to commissioning as part of a more general dilemma caused by constant policy change, which frequently resulted in public health professionals being expected to undertake tasks for which they received little or no training (an issue discussed further in sub-section 12.3).

*10.1.2 The provision of sufficient resources*

As with many new initiatives, there were concerns expressed by those expected to implement policy directives around joint commissioning that a lack of resources may also hamper success. For many of the interviewees this wariness arose within a context in which public health frequently loses funding to other parts of the health system (as the fate of much of the *Choosing Health* monies highlights – see above, sub-section 9.3.6). Many of the interviewees were therefore quite pessimistic about the likelihood that this issue would be effectively resolved, as the following quotations illustrate:

NGO: *'It [effective commissioning] also needs resource. I mean there's always the danger we are seen to be asking for more resource to make things happen but actually… there's lots of evidence to show that implementing the best evidence in itself costs more money - you know, surprise, surprise - bringing about better quality services and so on, does cost money. And that's not to say that there's lots of things that we can't do in the system to make existing systems more efficient and so on, but often to make the real step change that's required does require more resources…'*

PCT: *'I think that the Commissioning Framework, it's in the right direction, again it's just a different way of working, which I welcome, but it needs to be backed up by funding, and that's one drawback.'*

DH: *'You've always got the barrier that there's never enough money to do any of this sort of stuff, you know, where do you start? Particularly as we're into much tighter financial regimes from now on, and there'll be the usual scrabbling around in public health… actually trying to get the resources.'*

However, some of the interviewees, particularly RDsPH and those based at the Department of Health, were keen to emphasise that a focus on limited funding should not be seen as an excuse for a lack of achievement of public health outcomes. Several cited examples of low-cost initiatives which they perceived to be effective as evidence that limited resources did not necessarily pose the barrier that other interviewees might suggest.

*10.1.3 The achievement of more collaborative working*

Although, as already discussed, policy imperatives to joint commissioning for health and well-being were perceived to aid the development of public health partnerships, the barriers working against effective collaboration were also viewed by many of the interviewees as a potential threat to the success of commissioning. In the following quotations, a range of problems facing partnership working is highlighted, including confusion around which organisations are responsible for which aspects of commissioning, and conflicts between different organisational arrangements, including contrasting performance assessment mechanisms (a point already highlighted above in sub-section 9.3.2):

SHA: *'I suppose the barriers are potentially a lack of understanding at what's required by the corporate entities of the NHS and local authority organisations,[…] and I think we need to have an organisation's success or otherwise partly judged on how they work in partnership with other public sector organisations at a local level to*

*deliver improvements in health such as you would have reflected in a joint strategic needs assessment, and local area agreements are delivery mechanisms for that.'*

PCT: *'I mean we're still stuck, to some extent, with different priorities, different timescales, in between different organisations, so that's still a bit of a barrier.'*

NGO: *'Local authorities have got a great history of public health improvement, and they see themselves often as the lead public health agency, and quite rightly in many cases, but, unfortunately, so do the NHS. And so the new Commissioning Framework, I don't think it's a good document, I think it's a bit woolly, and it doesn't make the accountabilities and the priorities very clear. And what's happening already is that Directors of Adult Social Services and Children's Services are running off with this agenda in one direction with local authority executives, and Public Health Directors are running off in another. […] And it's just pulling health and wellbeing in a different direction. […] I think the enabler's got to be that we've got to get a much smarter thinking about how to commission for populations across sectors, so we can't just be thinking about 'oh this is the bit we'll commission as Health Service people, this is the bit we'll commission as Social Services, or Environmental Services or whatever', there has to be a whole system approach locally to commissioning for public health and for health improvement and well-being.'*

The last quotation reflects a concern which is also evident more generally in the data, that there was a perceived lack of clear guidance around partnership responsibilities and the implementation of the commissioning agenda from central government. In fact, as the following sub-section discusses, many of the interviewees suggested some of the other recent policy initiatives that the government has put forward appear directly to conflict with the aims of commissioning for health and well-being.

*10.1.4 The provision of a coherent and supportive policy context*

Much of the cautiousness surrounding commissioning for health and well-being seemed to relate to many interviewees' concern that, whilst potentially useful, it was not an approach which they felt would, in itself, solve many of the problems facing public health. Or, as one RDPH summed it up, 'it's only one bit of the jigsaw'. It would be unwise to focus public health expectations on its success, especially given rather overblown expectations. In order to be successful, many interviewees felt the commissioning framework needed to be underpinned and accompanied by clearer directives and incentives for local actors to work with:

PCT: *'I think some of the barriers are still that beneath the ideas [in the Framework for Joint (sic) Commissioning for Health and Well-being], there's a lot you have to work through. We're trying to do it here, in terms of how you manage that in terms of governance and partnership working and resourcing. So, whilst I think[the Commissioning Framework] sets the parameters, it doesn't help you move forward an awful lot in terms of how it's actually going to work in your local area. You need a lot more thinking and working through if you're actually going to get a system which truly shares public health priorities and action.'*

SHA: *'I think the Commissioning Framework… probably didn't say anything that people would disagree with. I don't think there was much disagreement from anybody from the consultation that I was aware of in my patch. There's nothing in*

*there that people would say 'actually this is totally outrageous'. [...] The trick's going to be about how much emphasis and priority will be given at the local level and at the national level on this. And it comes back to the levers and the alignment points I was making earlier, because if something is given a huge amount of emphasis and it's reiterated in every performance improvement process that this is an important agenda, this needs to happen, then people out there who deliver on it, recognise that yes this is, and yes it needs to happen.'*

DH: *'I think it will be successful but not necessarily as successful as it could be. I mean I think there are still issues about the need to raise awareness and create better understanding of the reasons why people should be interested in this and, in part, it really requires a stronger focus on the arguments that support particular policies and this is the bit about linking the general information to the actual delivery. You know, when you work in partnership in the messy world of management, what you learn very quickly is that you actually have to understand the motives of individuals and how you can motivate people to take on board an agenda.'*

In addition to the perceived need for clearer guidance and incentives around commissioning for health and well-being, many of the interviewees expressed frustration at the lack of coherence between the commissioning agenda and various other recent policy initiatives. For example:

DH: *'I think some of the building blocks work against each other. For example, the foundation hospital business seems potentially to undermine the local commissioning plans of the consortia of commissioners because, actually, it's in the interests of a hospital to get the maximum number of people through, not to prevent them coming through. So we've set up something that's called payment by results - it isn't really payment by results, it's payment by activity - and we're not really thinking about the desirable outcomes. What we want is hospital services that will take pride in the fact that patients don't need to come to them again and will support what goes on in the community because that's the right thing to do. So there are bits of the system that are working against each other. Demand management in primary care versus the magnet effect of the big hospital. That's very, very tricky.'*

As already discussed in sub-section 9.4, practice-based commissioning (PbC) was the policy most often highlighted by interviewees as one which seemed potentially to conflict with the aims of joint commissioning for reasons to do with both scale and inclination. Interviewees commented that much PbC functions at a level and scale that renders joint commissioning virtually impossible and, even if it could be made to work, most GPs have no experience or understanding of working with local government and little if any enthusiasm for such a task.

### 10.1.5 Organisational and policy stability

Relating to the concerns discussed above, several interviewees were keen to suggest that, if commissioning for health and well-being were to be successful, it would need to be given space and stability to develop effectively. These comments were often made in the context of frustrations about the raft of recent reorganisations (see above, sub-section 9.3.5), as the following quotations illustrate:

SHA: *'I think in theory everyone wants that to happen. The real problems with this are getting the stability of contracts. You know, first of all organisations have been reorganised, and then teams disappear and then budgets disappear. You know, it's very difficult for either businesses or the voluntary sector to be able to deal with, handle this. It's just impossible to run a business that way. So there needs to be, I think, some stable commissioning. I think there's no problem philosophically in doing it now with any of those groups, it's the practicalities I find problematic, really.'*

NGO: *'I think it will work as long as we don't kind of, that our expectations are not too inflated. I think it will work if people understand that both commissioning for change and the public health agendas, whilst you can have some quick wins initially it does take a long time to see any real change. And I think it mustn't become a political whim that's swept away should we have a new kind of political administration, because I think it has to have some longevity, it has to really have time to bed in properly.'*

This finding is indicative of the fact that, despite the expression of a range of reservations about recent developments in public health, including the commissioning agenda, nearly all of the interviewees were keen to advocate a period of 'bedding down' in public health, in which they could concentrate on trying to implement recent policies effectively rather than having to understand new initiatives (again, see sub-section 9.3.5).

*10.1.6 The use of available evidence in making decisions about commissioning*

The importance of basing public health decisions on the available evidence and information was an issue which interviewees raised in a range of contexts but, to several interviewees, was something which seemed to be particularly important in regard to local decision-making around commissioning activities:

NGO: *'I think if people really wanted that to happen then it could do, but it has to be absolutely embedded across the system, so that when people are making decisions about commissioning the very first thing they ask is ' what do we know about existing services? What data have we got? What evidence have we got about whether they're working or not? What evidence is there around about whether there's a more cost effective way of doing things?'*

As the above quotation suggests, comments about the need to base decisions on evidence were usually made in the context of suggestions that this was far from the current reality. Indeed, some interviewees suggested that it was difficult to obtain the kinds of information they required to make decisions about commissioning. All this suggests that, despite official commitment to the idea that policy and practice should be based on information about 'what works', the current reality is a long way from evidence-based (or even informed) policy and practice.

*10.1.7 Increased public awareness, and therefore involvement in and support for, commissioning for health and wellbeing*

The final factor which several interviewees suggested was essential if commissioning for health and well-being was to succeed, was an increased awareness of public health issues among the general population, as the following interviewees articulate.

SHA: *'I think we're on the right track. I mean the experience that we've had in this region with tobacco control, if you fund a bit of effort in lobbying, advertising, general marketing issues, you can get public opinion to change. Once public opinion changes, then delivery of the programme and commissioning of the programme is easier.'*

NGO: *'What the role of the people who ran the [Blank – programme] in [Blank – council] was, we almost advocated and configured and commissioned services on behalf of [that social group]; we became their commissioners. So instead of us being the commissioners of services, we actually became the commissioners of what [that group of people] wanted, and I just think that's such a fundamental shift.'*

SHA [different to interviewee above]: *'I think it's about the role the public should be playing in terms of influencing commissioning, full stop and the fact is that people are interested in their health. And we ought to. We ought to engage the public much more in thinking about the broader aspects of public health policy, but that does require us to take the agenda to the public in a way that we don't do at the moment.'*

Commissioning for health and well-being, like many other public health initiatives, was thought to be more easily achievable in a context in which the public were more involved in and more committed to public health goals. Whilst this seems reasonable, there were a number of concerns about how the goal of increased public awareness and involvement might be achieved, a point discussed further in sub-section 10.3.

## 10.2 Partnership working

In addition to being an activity which many interviewees felt was being actively promoted by the commissioning agenda for health and well-being, effective partnership working is something which the three post-1997 governments have promoted as being of central value to public health in its own right. Partnership working is hardly a new or novel idea - it has formed a major plank of health policy at least since the first major NHS reorganisation in 1974 and probably before that - but successive accounts of its effectiveness have suggested it remains patchy and uneven. A question arising out of the current reforms is whether this can change in future, especially in a context in which partnership working is becoming more complex as a result of its sheer range and diversity. In particular, with the government keen to promote third sector involvement in service provision, the nature of partnership working is changing.

The interviewees' comments suggest that efforts to strengthen partnerships are widely supported amongst those working to implement policy change, but that they have so far met with mixed success. Whilst some interviewees reported extremely positive accounts of partnership working in their locality (or region), through LSPs and other arrangements, there were also a few very negative accounts. Overall, the most frequent response was to suggest that efforts had clearly been more fruitful in some areas than others, as the following extracts attest:

SHA: *'It varies from place to place. And in some areas, particularly where they've had a history of partnership working in the past, it's really steaming ahead. I mean in [Blank – area], for example, it's absolutely fantastic, and it's probably the most collaborative I've seen anywhere ever in my whole career, I really think it's going*

*fantastically well. But then other areas, particularly where there are internal conflicts within local authorities and within the health community, and where money is tight, then things are not going very well at all, then there's only very grudging acceptance of the need for partnership working, or sometimes the acceptance is there but the reality is quite different.'*

NGO: *'I think it [partnership working] is inconsistent across the country. I think where there's been a history of people working together, perhaps even before we started formally calling it partnership, but actually where people have been in the same local place and have been kicking around for 20 or 25 years and have been getting things done, then actually I think they do seem to work. And they've got some maturity and there's some respect and some trust and they're focused. I think where they've been flung together because there's an imperative to do so, but actually that people don't really understand what it is that they're supposed to be doing, they don't really feel any confidence in terms of if they have any clout locally to make things happen, then I think partnerships don't work, frankly.'*

Some of the factors interviewees deemed important in determining the success (or otherwise) of partnership working are mentioned in the above quotations, including: the extent to which partner organisations (and individuals) had previously worked together, the level of trust/antagonism between partners, and arrangements relating to resources. Other factors which interviewees suggested impacted significantly on the effectiveness of efforts to promote partnership working included: whether or not boundaries between partnership organisations were coterminous, and whether partnerships shared the same targets, incentives and performance assessment arrangements. Each of these factors is briefly explored in turn.

*10.2.1 The extent to which partner organisations (and individuals) have historically worked together*

As both of the quotations above demonstrate, a history of partnership working was often seen as a key factor determining the success of current attempts to work collaboratively. Where organisations had previously worked together, many interviewees suggested this had allowed structures to develop which helped promote ongoing efforts to collaborate and often resulted in a perception that working jointly was the norm, rather than something which was the exception and had to be worked towards:

Local government: *'[Partnership working here] really has had a lot of time to form and norm and all those things. So it's had a lot of time to embed itself, and so its history is very important. And I think sometimes we sort of gloss over the importance of people who know each other quite well and have worked together for some time as giving you a very strong foundation. So I think that helps enormously.'*

Additionally, interviewees suggested a successful history of partnership working was often associated with sound levels of shared knowledge between different partner organisations and a level of trust which could not necessarily be quickly developed. As the following sub-section discusses, a relationship of mutual trust between partner organisations was considered to be extremely important in making collaborative working effective.

*10.2.2 The level of trust / antagonism between partners*

The extent to which people working within different organisations feel that they can work with one another, and the extent to which they trust both the partner organisation and the individuals who work for it, were viewed by many of the interviewees as crucial to the efficacy of organisational relationships, as the following interviewee reflects:

DH: *'I think it goes back to the fact that they think it's an important set of longer term objectives for their area, and they like working with each other. Like I said it's looking at all manner of different things. I don't think it's the form of organisation and I don't really, deep down, think it's even the money, except at the most extreme edge. I think it's about whether people can settle as an effective working network. And a lot of things influence that: a bit of ambition; a bit of liking working with the people that you're with. A focus on outcomes I think is perhaps the one thing I would say that is really important. A lot of people go through the ticking the box ritual so that CLG and Department of Health are satisfied. It needs more than that.'*

The difficulty with focusing on issues such as the level of trust between organisations, and the importance of having a history of partnership working, is that these are issues which are not easily identifiable and are not factors which can readily be replicated. Furthermore, it would be difficult to design a policy which had the specific aim of developing trust between several types of organisation as the key factors are likely to be specific to different contexts. Therefore, whilst many of the interviewees suggested these issues were important, they were not necessarily the issues which interviewees felt policymakers ought to be addressing as a means of helping collaborative working to take root.

*10.2.3 Coterminosity of boundaries across organisations*

In contrast, coterminosity of boundaries between partner organisations was just such an issue and was a subject which arose in every interview. Whilst several of the interviewees suggested that it was important not to overemphasise the benefits of coterminosity, or conclude that effective partnership working was impossible without coterminosity of boundaries, no one thought it was irrelevant and many, such as the following interviewees, felt it was crucial:

PCT: *'I can only really talk about the local level, but our bit makes a whopping difference, absolutely enormous. And really, my own view is the Local Authority boundaries, wherever they are, are usually the fixed boundaries. And I know there are some changes across country, but really in some ways health needs [to] fit with Local Authority boundaries.'*

DH: *'I mean we heard no end of feedback on areas such as [Blank] where there's one local authority and there was I think five PCTs resulting in internal fighting as to who from health actually sits on any sort of partnership body. So I think, generally speaking, coterminosity can only be good, if only because the players sitting around the table are actually focused on the same area and on the same problems.'*

PCT: *'I think [coterminosity of boundaries] is, having got that now, we haven't had it for five years, it's really important. It's vital, really. I mean, I have worked in the past in, it is so much harder to work when you're not coterminous.'*

Most of the interviewees, including those quoted above, discussed coterminosity in relation to the local level (between PCTs and local authorities) and it was at the local level that coterminosity was deemed by many to be essential to effective partnership working. However, where coterminosity of boundaries at the regional level was discussed, interviewees generally felt it was also important.

Yet, whilst nearly all of the interviewees were in favour of achieving coterminosity of boundaries (at the local level, at least), the high levels of resistance to further organisational restructuring suggests a desire for sharing boundaries was not of paramount importance and not one interviewees felt ought to be achieved at any cost, especially as the recent raft of organisational reforms were suggested by many interviewees to have been extremely damaging to relationships between PCTs and local authorities (see sub-section 9.3.5).

*10.2.4 Shared targets, incentives and performance assessment arrangements*

As sub-section 9.3.3 has already discussed, one of the key factors which many of the interviewees felt policy directives ought to be more effective in encouraging was the development of shared incentives, targets or goals to work towards. A positive example where several interviewees suggested this had recently occurred was around smoke-free initiatives, as the two interviewees quoted below claim:

PCT: '*I think one thing that is galvanising us all is the smoke free agenda. I mean that's great, but that then the timetable is driven nationally by everybody, and that has brought a lot of people together. So it's been fantastic because everybody has to do something by the 1ˢᵗ of July, and we are important players because we have the smoking cessation services, and that has been a really very interesting one. So in a way maybe it needs something of that sort to bring it all together, and if you can find something else where you've got that sort of deadline, then it might galvanise action that would otherwise just drag on. [...] There's a danger of getting rather wishy-washy in partnership but a deadline that everybody has to work to, or hard data, that's really quite difficult to ignore.*'

SHA: '*I think we can point to some really powerful examples of the partnership working, and the obvious one to pick would be the smoke-free initiatives, where right through from local community groups backing it to senior politicians, and the local authority and the NHS putting money into the campaigning, you know right across the board, people said, 'we're going to do this, we're up for it,' and there was real involvement in a single issue. For that, there was evidence of real partnership .. because you had people from several organisations involved in it, saying the same thing. So it's [having a] single message, single issue, shared commitment to see change [which] I think has probably been really helpful.*'

In addition to a perceived need for joint targets and goals, as sub-section 9.3.3 also highlights, several of the interviewees felt there was a need to link the currently separate performance management systems governing local authorities and PCTs together.

*10.2.5 Arrangements relating to resources*

The provision of joint targets and performance assessment mechanisms were not the only things which many of the interviewees felt ought to be shared across organisations. The separate budgets for contributing to public health initiatives held by local authorities and PCTs were thought by several interviewees to hinder collaborative working. In the following extracts, the first interviewee reflects on their suspicion that they could work more effectively as a *joint* DPH if the local authority contributed to funding their post. The second and third quotations refer to funding issues more generally:

PCT: *'I can see that logically joint funding might make a difference because if the Local Authority were paying half of my salary, I suspect that I'd be held to account rather more rigorously by the local authority than is the case at the moment. I mean, ideally, I would like to say that it doesn't make any difference but, in practice, I think it does.'*

PCT [different interviewee from above]: *'Pooled budgets, use of reward grants, focus the mind [...] And I've certainly seen how partnership priority areas where we're not doing well and yet the councillors are getting beaten over the head about them, it's certainly raised the ante very noticeably, for getting other partners to get their act together.'*

SHA: *'At the moment though even within the LAA, my understanding is that the funding still comes down relevant government department streams. But if they move to the next step and actually say, 'here is a pot of money and it's for all of the agencies' that's going to create a new dynamic of people really having to get into conversations about who gets the investment and why.'*

For many interviewees, Local Area Agreements (LAAs) and joint DPH posts both represented moves towards linking funding and priorities across local authorities and PCTs and many were hopeful that these moves would contribute a great deal towards effective partnership working and to the achievement of better outcomes.

LAAs were widely perceived by interviewees to represent an extremely positive development within public health. Most were optimistic that they would help promote joint planning and would provide mechanisms for linking incentives and rewards across local authorities and PCTs, as the following quotations demonstrate:

Local government: *'I think the LAA, as a vehicle for delivery in joint planning, is very targeted, very focused.'*

SHA: *'I think Local Area Agreements are brilliant and are going extremely well. [...] The LAAs have very heavy – very substantial in some cases – reward grants associated with them. So putting together a good LAA with a high health content and significant sums of money flowing from that, I think is quite an incentive for good partnership work.'*

DH: *'[LAAs are] fundamental. This is the actual mechanism for really bringing organisations together much more powerfully than tinkering around with the organisational form. The local area agreements are rapidly becoming the centre of the contract with central government. Now we don't know what the national targets*

*will be but, in a way, that doesn't matter because they're probably going to be reasonably well formed, reasonably sensible, and it's what you add to them locally that matters. And the LAA, I think, are moving from being signposts to being blueprints. [...] Too many of the partnerships at the moment are not connected to the outcome side, and the LAA I think connects it to the outcomes.'*

SHA [different interviewee to above]: *'[Initially] Local Authorities clearly were driving [LAAs] and I think, to be fair, some of the NHS organisations weren't really taking Local Area Agreements that seriously to begin with. Now I think it's a different ball game completely. We've got Chief Execs of PCTs who are leading on Local Area Agreement work, and very, very keen to see it really happen, in a way that I wouldn't have seen three years ago. And I think that's been a great way of gelling things.'*

In fact, aside from one RDPH's concern with the increased bureaucracy the implementation of LAAs had brought to his/her region, the only negative comment regarding LAAs related to the possibility that the constantly shifting policy environment, combined with the limited resources available within public health, may mean that they were prevented from reaching their full potential.

*10.2.6 Joint DsPH*

Most interviewees were broadly supportive of attempts to create DPH posts that are jointly appointed by PCTs and local authorities. On the whole, interviewees felt that these posts helped join up the differing infrastructures of PCTs and local government, that they provided a bridge across cultural divides, and that they helped both organisations understand which aspects of public health they ought to be focusing on. However, interviewees also suggested that there were currently a number of factors working to limit the effectiveness of these posts. One of these issues, that many of the posts remain solely funded by PCTs, has already been touched on in sub-section 10.2.5. Illustrative quotations relating to other factors that emerged as concerns in the data are summarised in Table 10.1.

*Table 10.1: The difficulties facing jointly appointed DsPH facing difficulties (aside from issues relating to funding of the post)*

| Difficulties facing joint DPHs | Illustrative comments |
|---|---|
| Cultural differences between LAs and PCTs | NGO: *'The trouble is [...] there's no understanding of the… difference in the two cultures. It's an amazing difference between the PCT and the LA. [...] You have to do so much work to prepare these two cultures to be able to work together effectively and the same is true of the poor old person who's stuffed into a joint post because, unless they're aware of all the baggage which comes with it and how they've got to spend months, if not years creating the right… circumstances and resourcing environment to work effectively together, you just tread on toes rather than bring it together…'* |
| Needs to be supported by | NGO: *'There's this idea that somehow the creation of joint directors of public health is going to change the world that we live in and part* |

| changes in broader infrastructure | of the reforms that have been happening recently is the recommendation for jointly appointed Directors of Public Health, obviously where PCTs are coterminous for the local authorities… but if it's the same old person, doing the same old things, in the same old way and with the same old boss, with the door shut, joint DPHs are going to have no effect whatsoever. So joint DPHs need to be part of joint public health systems – they will not affect any change in isolation, even if they are jointly appointed.' |
|---|---|
| Joint in name but little else | DH: 'Frankly, if you can define for me what a Joint Director of Public Health is then I'd be really interested to hear it because actually often the title is the only thing that is consistent and the same between different areas. The role is very variable. […] I think all too often it becomes an excuse for saying that you're doing things rather than the reason for just saying that you are doing things.'<br><br>'Sometimes I think that they're joint in name and potentially… not very genuinely joint. So you can have a joint Director of Public Health but who is very PCT-oriented so I think that's something else. Just because you have one in name doesn't necessarily mean that you've joined everything up.' |
| Lack of clarity around accountability and aims of these roles | SHA: 'We've got some sort of acting appointments but we can't fill the roles, and part of that is the lack of clarity around the real accountabilities of the role.'<br><br>DH: 'The bit that I find slightly frustrating is that too many of these posts have been created without people actually defining the outcomes that they want this person to achieve, and if that had been done, then it would have been far more productive than simply plunging into a the solution is a joint appointment.' |

The difficulties interviewees described in relation to the functioning of joint DPH posts echo a variety of the problems facing public health more generally that this scoping study has already touched upon. In particular, the barriers working against effective partnership working, especially between local authorities and PCTs (see sub-section 10.2); the need for a coherent approach to public health, in which the current variety of policies are more closely aligned and inter-linked (see sub-section 9.4); and the feeling amongst interviewees that clearer guidance was required for many of the recent policy initiatives (see sub-section 10.1.4), have already been discussed. This suggests that the difficulties facing those individuals trying to operate effectively as joint DsPH in fact reflect broader problems facing public health, which might best be dealt with by a more widespread review of public health policy and what it is intended to achieve. Certainly, as several of the quotations in Table 10.1 make clear, it would be unfair to expect the creation of joint DPH posts alone to overcome many of these quite profound problems.

*10.2.7 Public health outcomes*

It remains to be considered whether or not interviewees were supportive of partnership working as a means of achieving public health *outcomes*. For some interviewees, as several of the quotations in the previous sections suggest, the

importance of being able to work collaboratively within the field of public health seemed relatively unquestionable due to the complex and multifarious nature of the factors which influence health. However, other interviewees were keen to emphasise that being able to work effectively in partnership with other organisations did not automatically mean that different, or better, health outcomes would be achieved:

SHA: *'Most local area agreements are lists of what the partners were going to do anyway on their own. So they are not, there isn't added value to be seen from the partnership, there aren't obvious targets where somebody has said, 'we, the NHS, will help you, the local authority, hit your target,' or vice versa. So I think there's a lot of political window dressing associated with that [partnership working]. [...] If partnership working is part of the evidence base and part of the rigour with which you would pursue your target then that's appropriate, but it isn't an outcome in its own right. Sometimes the topic itself doesn't have the necessary evidence that a partnership will make the blind bit of difference, so why would you have one? [...] It's sometimes like a commonsense application of principles that we'd be better doing this together than apart and that does smack of worthiness rather than of rigorously evaluated evidence?'*

PCT: *'It's very unpolitically correct for me to say so really [but] there are some aspects where partnership working is oversold, and you might actually do better on your own without being, coming together.'*

A couple of other interviewees were also keen to highlight that the desirability of a partnership may depend on the partners involved; not all organisations or sectors were seen in a positive light by all of the interviewees. For example, the following interviewee was rather wary of partnerships which involved certain sections of the private sector:

NGO: *'I think there's a lot of naivety about what partnerships are. For example, particularly with the industry, I think we have, you know, there are some inappropriate partnerships in public health which I think are unprofessional and actually damage public health, particularly with commercial interests. I agree with the dialogue with the commercial interests but I think some of the partnerships are not merited, and are also too early, because the commercial partners haven't embraced the sort of change [required]. I mean they profess to but the reality is that they haven't, therefore I don't think we should be entering into partnerships until there's some genuine concrete commitment towards that. Particularly, for example, with the food or the alcohol industry [...]'*

Tensions within the data about which individuals and organisations different interviewees believed had something positive to contribute to public health were most overt in relation to discussions about recent policy emphases on the importance of choice. These issues are therefore explored further in Section 11.

**10.3 Public involvement**

As in the case of partnership working, the involvement of the general public in decision-making is a development which has been actively encouraged in recent policy statements (see, for example, the *Choosing Health* and *Our Health, Our Care Our Say* white papers – Secretary of State for Health 2004 and 2006) and was often

discussed by interviewees as an intrinsically valuable objective in its own right, reflecting the emphasis on community engagement as an underpinning value for a public health system. However, there is evidence that effective public involvement continues to be elusive. For example, a research project entitled *Strategic Action Programme for Healthy Communities* (Pickin et al. 2002) identified the lack of a strategic approach to working with communities and explored the organisational changes required in the public sector if the commitment to developing more effective partnerships with the community was to be achieved. Public sector organisations found it hard to engage with communities for a number of reasons, including: the community's capacity to engage; the skills and competencies of staff within organisations; the professional service culture; the overall organisational ethos and the dynamics of local and national political systems. Other research demonstrates that collaboration and partnership with the voluntary and community sectors is effective for building community relationships (Farrell 2004). With the creation of Local Involvement Networks in every local authority area in 2008 (following the Local Government and Public Involvement in Health Bill) it is hoped that local communities will exert more influence on local public services. It remains to be seen whether the removal of responsibility for patient involvement from the NHS to local government will be reflected in a broader approach to public health and well-being and whether their work will be influenced by the priorities of joint needs assessments.

Most interviewees felt that the public health community had been particularly poor at involving the public in decision-making to date. For example:

DH: *'Many of the people who talk about patient and public involvement, about expert patients, about a patient-led NHS, actually don't get it, because as soon as patients do start making real choices, we try to stop them again. So we say we want them to do that but we will not follow where they lead. And so my concern is that there's still a kind of paternalistic intent so that, if you like, public engagement becomes a trick instead of a proper intention. It becomes a sort of thought of, 'oh well, we can use public engagement just to trick people into doing what we want and what we've decided they ought to do in the first place.'*

NGO: *'I think any public health system needs public (and) community involvement, and again I think that's been a real area of weakness in public health systems certainly in recent times. [...] [The public should have a] much bigger role than the role they've got at the moment would be my view. I think, and local government and the NHS are equally guilty of this, but probably the NHS is a bit more guilty than the local government, they're all 'doing to' organisations. I often feel that where public involvement has been encouraged and welcomed is in areas where the public can't actually do a lot of damage, you know, [...] and some quite rightly. So, we're not going to have a committee of community people in the operating theatre deciding on what the surgeon's going to do.'*

In addition to suggesting that recent attempts to engage the public in public health decision-making had been rather limited, the above quotations also reflect the widespread desire amongst interviewees to address this issue. This was a sentiment which sub-section 10.1.7 above has already reflected on in relation to commissioning for health and well-being, and it was a feeling that was widely held by many of the interviewees more generally in regard to decision-making over public health

priorities. However, a couple of the DsPH and RDsPH who were interviewed were notably less enthusiastic about involving the public in decisions about public health. The following extract is the most overt example of this within the interview data:

PCT: *'I'm frightfully unpolitically correct - I'm almost wanting to say that I think I know what the priorities should be from the data and so on, and if I involve the public, it's just because I know implementation will be harmed if they don't believe it's their idea in the first place. And that is being deeply cynical isn't it? Because that is not actually saying I want them to come up, naturally, with what the priorities are, I'm saying - because I'm an arrogant sort - that I think I know what the priorities are but I'm going to try to engage them to sort of come up with my priorities. So it is quite difficult because when you do get public meetings and so on, they keep on focussing down on closure of the acute hospital or […] I mean occasionally there's something that comes up about TB, 'all those nasty foreigners bringing that awful disease', and so it's completely, you know, if they bring it up, it's over-egged and embarrassing so you have to put it back into the box.'*

Another interviewee felt that the public were growing increasingly tired of being asked for their opinion on policy decisions and that the job of local practitioners and central government policymakers was to make decisions in the interests of the population. While only a small number of interviewees suggested that these were reasons to avoid too much emphasis on public involvement, many other interviewees felt these were issues which needed to be confronted if public involvement was going to be successful. Yet, while most interviewees were supportive of the general principle of involving the public more actively in decision-making, the data reveal a tangible lack of knowledge about how best to achieve this aim. As the following quotations illustrate, several interviewees were concerned with the ineffectiveness of current arrangements and yet were equally unclear about what better alternatives might be available or involve:

PCT: *'I think there is a gap in terms of how we, I think it goes back to the Wanless Report really, how do we really motivate, empower - all those kind of words - more general engagement of local people? And how do we get local people to actually demand improvements in health and expect them and be engaged in those kinds of issues? […] It's something we haven't really done in the past.'*

Local government: *'If you went down a busy street and asked people what they thought about health, they would be likely to talk about hospitals and their uncle Bob and his experiences – unclean wards or whatever. So you've got a real challenge there. Before you can involve the public effectively in the health and well-being agenda, you have to do some education around what that is – about people's health. So that's a fundamental challenge really.'*

PCT [different interviewee to above]: *'How do you engage with the public? How do you find out what they think about public health issues and how do you ensure that their comments, their views, are well-informed because, at the end of the day, they're not, Joe Public isn't a public health specialist and so they may come up with things and say things are important that, objectively speaking, aren't. And that's a real challenge.'*

In addition to the lack of confidence amongst interviewees in relation to their knowledge of how most effectively to engage the general public in public health agendas, a recurring concern in the interview data in regard to public involvement (and one which is evident in the quotations above) is that public perceptions of what constitute public health problems are not necessarily the problems on which public health practitioners and policymakers are currently focused. In light of this, several interviewees felt a significant amount of public education was required before the public could be usefully engaged in making decisions about potential public health options. Some of these frustrations are reflected in the limited research which has specifically explored lay perceptions of prominent public health issues. For example, the limited research that has been undertaken in relation to public perceptions of health inequalities found that, overall, the public do not tend to be overly concerned about health inequalities (Blaxter 1997) and, furthermore, that the individuals who are most likely to experience the negative effects of health inequality (i.e. those living in difficult social or economic circumstances) tend to be more reluctant than others to accept the existence of health inequalities (Popay et al. 2003), possibly due to the stigmatising effect that accepting the existence of health inequalities can have on communities and individuals.

Other concerns that interviewees discussed included uncertainty about how to avoid the trap of having the same, not necessarily representative, groups ('the usual suspects') repeatedly contributing to debates whilst most of the population remain unengaged, and the difficulties involved in getting the public to think about dealing with potential, rather than actual, health problems. The former is an issue raised by Tritter and Lester (2007) in their recent analysis of how emphases on the importance of user involvement link to the policy priority of tackling health inequalities. Here, they reflect that 'patterns of health inequality are also reflected in those who tend to be involved and those who are members of 'hard to reach' groups' and conclude that, 'Unless user involvement draws on the diverse range of the population and aims to be inclusive, it can only serve to reinforce existing patterns of health inequality.' (ibid: 175).

As has already been highlighted, many of the interviewees felt that the public health system ought to engage more effectively with the public. For some, this was one of the ways in which they hoped the public health system would improve over the next five years:

Local government: *'I would like it to become more holistic and generally, the public to understand much more about what we mean. I'd like public health to be doing more of the public inspiration stuff and culture change and thinking more creatively about the skills that it needs actually. [...] If it's going to be really improving people's health and reducing health inequalities, it needs to be much more creative and inclusive and open to learning.'*

SHA: *'I'd like to open up more understanding in the public's eye about the impact, you know, where good health comes from so that the system is much more transparent'*

For these interviewees, public health objectives were likely to be far more achievable in a context in which the public were more aware of the factors shaping their health

and were hopefully engaged with the aims, and committed to the objectives, of the public health system.

Many (although not all) the interviewees were thus more closely aligned with what has been termed the expert/evidence model of public health practice, rather than the leader/development model (Connelly and Emmel 2003) associated with a recognition of the role of public health advocates, interest groups and local communities in identifying and addressing threats to health. Greater involvement of disadvantaged communities is seen as key to addressing social exclusion and promoting regeneration. In this latter model the role of the public health practitioner is described as facilitating collective action to achieve health.

## 11. Markets and Choice

Markets and choice are twin pillars of the government's public sector reform strategy as it has evolved since 2004. The assumption is that more efficient, effective and responsive delivery of services both to treat and promote health can best be achieved through the application of market-style competitive principles. For choice to be possible and succeed, we are told, a market embracing a mix of services and providers has to be in place (Department of Health 2003) even if one of the major paradoxes of successful markets is actually the removal of choice rather than its active encouragement. The NHS reforms are therefore designed to stimulate diversity of provision (both for-profit and not-for-profit) and to bring to bear on public services and their providers some of the approaches and disciplines from the private sector. Quite how such approaches and levers are to work in the context of public health remains problematic and were a source of some confusion and anxiety among many of our interviewees. On the other hand, not all our respondents were negative and could see some potential opportunities to move public health in a new direction. However, as we go on to show, 'choice' is a slippery word that is open to many interpretations.

Consequently, interviewees' views on how recent government initiatives to promote choice might impact on public health varied extensively and were often dependent on what they understood the 'choice agenda' to involve. As the following definition attests, there were at least three quite different ways in which interviewees discussed this agenda: first, there was the frequently referred to commitment to increasing choice within the secondary care sector; second, several interviewees described a scenario in which similar choices could be made available for people who wanted to access preventative services, such as smoking cessation; and, third, a smaller number of interviewees suggested there was a need to think about people's choices on a grander scale, for example, in relation to their abilities to make decisions about where to live or work, or the kind of food they eat. Most of the interviewees focused on the first two understandings but the following quotation is one of several examples which draws on all three ways of thinking about what 'increased choice' might involve:

SHA: *'Choice is interesting and I think eventually people will begin the kind of segmented market approach to choice. People will choose certain things and they may well choose hospitals on the basis of quality but only for particular services, I think. So, where public health comes into that, where it should come in, of course, is*

*where they're looking to general practice and… where they want a particular preventive service… and they can't get it, then they might well want choice. I think the wider choice [agenda] is in terms of, if the public is thinking about choice of food, choice of facilities, choice of environment, you know, choice of the urban places that they live [...] And the real problem here… is about people choosing, say, housing options, is that people withdraw from the less mixed area, sort of more mixed areas the less salubrious places and choose ghettos of, well, better off people and leave a sort of a reduced but very vulnerable group. So I think, you know, when you say 'choice', you've got to think big here about what the big issues are in the way people live their lives and how this influences choice, and where [...] the real enablers of that are.'*

In addition to illustrating the various ways in which interviewees discussed the 'choice agenda' and, therefore, the lack of a clear conception about what such an agenda involves, the above quotation also begins to draw out some of the key concerns that interviewees expressed in relation to policy imperatives to 'increase choice'. Many of these focused on perceptions that opportunities to make better choices might be dominated by wealthier (and generally healthier) groups and these are discussed in sub-section 11.1 below. However, there were also a range of other, less specific, concerns expressed by some interviewees about recent policy emphases on choice and these are explored in sub-section 11.2. Following this, sub-section 11.3 moves on to explore aspects of the data which provide more positive interpretations of how the choice agenda could be employed to contribute to public health objectives.

### 11.1 Specific concerns about the impact of the choice agenda on health inequalities

Interviewees in every sector that we spoke to expressed concern about the impact that increased choice could have on patterns of already widening health inequalities, a concern which has been much discussed in the literature on the topic (Fotaki 2006; Fotaki, Boyd Smith, et al 2006; *Which?* 2006; House of Commons Public Administration Committee 2005; Le Grand and Hunter 2006; Le Grand 2007a and b; Williams, Calnan and Dolan 2007). The crux of these concerns was that those who were already more health aware, and those who had the most resources, would be more able to make choices, or access the better options, than the already socially excluded groups who populate the lower ends of social gradients of health (Dorling, Shaw and Davey Smith 2007):

PCT: *'My reservation is that choices are more easily made by articulate and well informed people and that whole basis of the inverse care law, where people are able to make demands on the system and make choices all the time, the people least able to make choices end up with the poorest services rather than the other way around.'*

Local government: *'It [increasing choice] is the same thing as focusing on lifestyle actually because it assumes that people are all as able to choose as each other. And we just know that that's not true. It will be the vocal internet savvy middle classes that will work out the value for them from those agendas and they'll be badgering their GP or whatever about the Choice Agenda. It's not going to be people who are socially excluded and marginalised and perhaps who don't speak English and so on. So I'm not sure about the whole Choice Agenda, frankly.'*

DH: *'We've been quite concerned about the choice agenda and we've been working with colleagues that are doing the choice stuff because we think, potentially, choice can widen the health inequalities, because you need to have… a degree of economic wellbeing to actually take advantage of the choices. I mean the very simple stuff, travelling away from your local area, and there are all these issues that you come to about understanding, and if people are in disadvantaged areas, or under doctored areas, which have poor primary care, is there access and is there choice? Much less than for somebody in a more affluent area, which has got much better health services. So we've been working very closely with Choice colleagues to see if we can mitigate against some of that…'*

The quotations above, all of which suggest that the government's emphasis on increased choice is likely to widen health inequalities, demonstrate a remarkable consistency of opinion across sectors. Interestingly, as the last extract illustrates, concerns about the potentially negative impact of increased choice in relation to the government's commitment to reducing health inequalities extended to individuals working within central government at the Department of Health.

As previously mentioned, however, a few interviewees believed that the choice agenda had the potential to help reduce health inequalities, especially if the changes encourage the provision of services that are more able to reach socially excluded communities. For example, several of the interviewees were hopeful that 'third sector' organisations, such as local voluntary groups, would become more involved in the promotion of health amongst hard-to-reach communities. For example:

DH: *'Potential advantages of a third sector are often closer to their communities - they understand them much more. Social enterprises reinvest back in the community, lots more local employment, […] comes through this. So there are potentially huge benefits of getting that system in place. So I think we will quite welcome it here.'*

It is certainly government policy that the third sector should actively help promote greater diversity in the provision of services and this is linked to the stated belief that this will encourage innovation and new solutions to familiar problems (Department of Health 2005). Such views, and the adoption of the choice agenda among at least a few of our interviewees, are also in keeping with the views of recent health policy advisers who have exerted considerable influence on the NHS reforms and on the government's thinking, notably Simon Stevens (Stevens 2004), Paul Corrigan (Corrigan 2007) and Julian Le Grand (Le Grand 2007a and b).

**11.2 General concerns with the choice agenda**

In addition to the potential for increased choice to exacerbate the existing social gradients in health, several interviewees were particularly concerned about what they viewed as increasing encouragement of the for-profit independent sector to play more of a role in the public health field. As the following quotation reflects, there was a significant level of suspicion amongst some interviewees about the intentions and motivations of independent sector organisations that have signed up to public health commitments:

NGO: *'What I saw often with the independent sector was, frankly, an independent sector screwing the NHS. So when it came to using them for additional capacity, it*

*was additional capacity at a ridiculous price. There is this naivety, as if some of the independent sector's in this …for philanthropic reasons, to make the health of the public better. Well I, frankly, struggle to believe that. […] I mean what the independent sector won't be interested in doing is promoting healthier lifestyles unless there's some payoff for it in terms of profit. […] And so the notion that Tesco's, for example, are all benevolent and 'oh, it's fantastic they all suddenly want to… put labelling on the ready meals about salt intake and calorific values and so on.' They're only doing that because they actually recognise that there's money to be made from doing it. I don't believe that they're in it to make people healthier…'*

Whilst some interviewees clearly felt that the independent sector had a lot to offer those working towards the achievement of public heath goals, in general interviewees were rather more comfortable with the potential for the third sector to play an increased role in public health, especially in regard to helping more socially excluded groups access health related programmes. However, in keeping with a recent study of the development of social enterprises in health and social care (Marks and Hunter 2007), other interviewees felt that the capacity in the third sector for providing a significant amount of health services was minimal. Additionally, some interviewees felt that the government's commitment to increase choice had so far resulted in rather more effort to engage with the independent sector than with voluntary groups, so that a level playing field could hardly be said to exist:

NGO [different interviewee to above]: *'I mean the moves to increase the plurality of providers seems to be focused much more on the private sector… and there seem to be lots of incentives, financial incentives for them to be involved. Clearly the Government, and all political parties, have a commitment to involve the third sector in service provision, but the reality is there haven't been any moves for that to happen. I also think that the voluntary sector, NGOs and professional groups can play a much bigger role in the provision of other types of things, such as policy and advocacy which I think should be properly funded. Because, at the moment, it isn't properly funded.'*

One interviewee said s/he felt there was no evidence to suggest that the voluntary sector was likely to provide services any differently to existing providers and therefore that it was unlikely to contribute much to addressing public health issues. A couple of other interviewees, including the following, expressed concerns that the third sector would be used as a cheap means of providing existing health services rather than as a source of innovation and a force for change:

NGO [different interviewee to above]: *'My fear is that the third sector will be seen as being a cheaper source of resource and actually we will engage with them and commission from them not because what they can do is better or more appropriate or more effective but because it's just cheaper than buying it from the NHS.'*

Overall, there seemed to be some level of uncertainty and confusion amongst public health professionals about what the 'third sector' had to offer, or even which kinds of organisations it consisted of. Whilst some interviewees focused on the potential role of the voluntary sector and charitable organisations, others mentioned social enterprises and social marketing organisations in this context, reflecting the wide variety of terms now used in discussions about the 'third sector'.

Separate concerns about the increased choice agenda related to a perceived lack of potential providers to meet many service needs, especially in areas which are already relatively underserved:

NGO [different interviewee to above]: *'In reality we know that in many places there aren't the polarity of providers, in many places and that the commissioning function is particularly weak. In many places people are just grateful to actually receive any service at all, regardless of the quality. [...] I think the world which those policies describe is at odds with the complexity of what it is actually like to be honest.'*

On the other hand, some interviewees felt that the logical conclusion of having a system in which a range of choices were on display was a system in which an excess of capacity would have to develop. For these interviewees, the choice agenda was perceived to be a potential drain on precious resources, which might otherwise be used to achieve public health objectives. For example:

PCT: *'I think [the likely impact of the choice agenda is] at best, neutral but, quite possibly, damaging to public health because… you can only provide choice in a system by having an excess of capacity so it'll make the provision of health services more expensive. And there's also a need for having additional management capacity to manage choice. So, potentially, what this is doing is using some of the additional resources made available to the NHS to support the whole Choice Agenda which could otherwise be used for public health.'*

The above interviewee's concern that increased choice is dependent on a system in which there is an excess of capacity contrasts directly with Le Grand's (2007a and b) claims that introducing choice and competition into public services works to increase efficiency and improve delivery. This difference of opinion underlines the varying ways in which individuals expect the 'choice agenda' to unfold.

**11.3 Positive comments about the choice agenda**

Beyond the concerns discussed above, there was also a significant level of support for increasing the choices of both commissioners and service users. As with many of the other policy developments that are currently unfolding, there were few unqualified statements of support for increasing choice; most interviewees' enthusiasm was very much dependent on how things developed. However, for a few of the interviewees, such as the following individual, there was a sense in which the basic idea that 'everyone should have a choice' was something they found difficult to criticise:

SHA: *'Choice has become a sort of pejorative term, it's become something that is linked to the independent sector and linked to assumptions about it as a lever for change. For me, shouldn't everybody have a choice to make about what happens to them and their bodies and their health? And really, the focus should be about enabling everyone to have a choice rather than saying choice is bad, bad for inequalities and bad for public health. Some of the most powerful conversations I've had have been around people in the most disadvantaged circumstances saying ' it's my life and I want to be able to choose'. But part of …the problem we have is that we haven't enabled people to have that chance, as a system we haven't necessarily made it possible.'*

Yet, as the above quotation illustrates, this essentially unqualified support for increasing choice was dependent on a particular interpretation of the choice agenda, one that would require far more than an increase in provider diversity of health services. Other comments that were supportive of the general ethos of increasing choice were all also highly dependent on the way in which 'choice' was interpreted, as the following quotations each demonstrate:

PCT: *'Ideally, we could have a sort of health improvement parallel to 'Choose and Book'. So, ideally, somebody calls in at their local practice and they have some sort of mini health discussion with maybe the practice nurse, maybe the GP, and you could quite quickly say, 'oh right, well you're interested in weight control,' or physical activity, put it in and have half a dozen different opportunities all within easy access of that particular neighbourhood. [...] So, ideally, you could say the choice agenda should be applied to health improvement and [...] we could be a lot more diverse in our provision of opportunities to help people so that they matched properly [to that person's particular needs].'*

NGO: *'I think the choice agenda can be played very much to the advantage of public health because it's about creating an environment that ensures choice and access. So you can use that as an argument for regulating to ensure that it happens as well as an argument for making sure there's plenty of information provision for the general public as well.'*

DH: *'I think it [the choice agenda] potentially can be quite beneficial. Whether it will be, again, depends upon how it plays itself through because people actually sometimes pay lip-service to the words and don't necessarily understand the underlying principles. I would struggle with people who got terribly excited about this and say it's wicked because poor people don't have choice. That's precisely why you have a choice agenda because, actually, what we need to do is to create more opportunity for people to exercise choice than has existed previously, and that's been, for me, the sort of primary reason for adopting policies that are encouraging creative opportunities for choice. But, again, I think it's matching the ambition and the rhetoric with the skills and the understanding to deliver it.'*

The extent to which interviewees' interpretations of the choice agenda varied is understandable in the light of two issues already raised in this review: the lack of clear policy guidance provided for those individuals and organisations expected to implement central government directives (see sub-section 10.1.4); and the confused and disjointed broader policy context (see sub-section 9.4).

## 12 The Changing Public Health Workforce

This section discusses three key aspects of the public health workforce. The first concerns the extent to which the workforce is multi-disciplinary; the second explores issues of workforce morale and recruitment, and the third looks at implications for training. Each is considered in turn.

## 12.1 To what extent is the public health workforce now multi-disciplinary?

Like many of the issues considered by this review, opinions relating to the extent to which the current public health workforce is multi-disciplinary depended on the way in which interviewees defined 'multi-disciplinary'. Those who suggested a multi-disciplinary workforce already exists either felt that not everyone who contributed to it necessarily saw public health as part of their role, or had a relatively narrow view of what constituted a multi-disciplinary workforce. The quotations presented in Table 12.1 capture both of these views.

*Table 12.1: Contrasting explanations for the view that a multi-disciplinary public health workforce exists*

| Explanation | Illustrative quotations: |
|---|---|
| Public health workforce is multi-disciplinary but not everyone involved occupies posts labelled 'public health' | NGO: *'I think it's all there, it's just sometimes it's not called public health and sometimes it's just not used very well, to be honest.'* <br><br> DH: *'I often have to pinch myself before I get into a debate about the public health workforce because I don't actually think of this group of people with sort of public health workforce labels and t-shirts on as they go round. I think of people across the whole of the public sector who have some aspects of public health work within their role and remit and who make a contribution. And therefore I don't actually necessarily usually distinguish between a group of full-time public health professionals and the broader public health or health improvement role of people who work in Housing or Education or in Benefits Services or in the NHS, in fact. So I always struggle when we get into this debate and I think that sometimes we almost create a bit of a paper tiger.'* |
| Public health workforce is multi-disciplinary now that an increasing number of non-medics are involved | PCT: *'Oh, it's very much a reality, certainly here in [Blank – city]. I mean I'm intending that when my consultant posts are all filled, they should be a mix of medical and non-medical posts. And the vast, in pure numbers terms, the majority of people who work in the public health directorate are non-medical, and there are some nurses and some others from other professional backgrounds, but the vast majority are non-medical.'* <br><br> PCT [different to interviewee above]: *'Certainly in my own senior team, of which there are four others, two are non-doctors, so it's half. There's only a smattering of doctors, very few, so they're clearly an absolute minority and we've certainly recruited some extremely good non-medical people. So I think we're getting there [towards a multi-disciplinary workforce].'* |

From the table it is clear that the first two interviewees' conceptions of what constitutes a multi-disciplinary workforce differ quite considerably from the second two interviewees' interpretations. The latter define 'multi-disciplinary' purely in terms of the mix of medical and non-medical specialists, whilst the former include individuals who are not necessarily even aware that their work contributes to public health objectives. Indeed, the divide between interviewees who focused on a medical model of health and those who focused on wider social and economic determinants was quite stark in several aspects of the data but particularly in relation to discussions

about the workforce.  For example, the following two interviewees were both keen to emphasise that they felt medical expertise was essential to achieving public health objectives, or at least to undertaking certain aspects of the work that DsPH are currently expected to take on:

PCT: *'I think that it would be a disaster if we don't maintain a fair number of medics in public health because I do think that medics have got a particular contribution to make.  And if there's a wholesale shift away from medics going into public health and being appointed to public health consultant posts, then I think public health will lose out.'*

PCT [different to interviewee above]: *'I'm conscious of what I do, in my day-to-day job, a huge amount of it is not technically public health.  I'm a Medical Director but also I cover a huge number of other things because I have a clinical background and because I'm jolly experienced at this, that and the other, which if I were not medical, a non-medical successor to me - and I warned them - I mean they would probably have to replace me with two.  And so they're not same [...] and I think that a medic is, must be inevitably must be versatile, there's more things they can pick up because of the experience they've had, but then they cost more, so you pay your money and you take your choice.'*

However, many other interviewees (especially those based in local and central government and in NGOs) felt that the dominance of a model of public health in which medical professionals were accorded higher status than non-medical professionals was a major cause of many of the problems dogging the current public health system.  In fact, an interviewee based at the Department of Health expressed frustration that some public health specialists working within central government did not take his/her views seriously because s/he did not have medical training:

DH: *'I'm reflecting some of my own frustrations around trying to get my colleagues in public health to take anything that I do in this area seriously because I'm not a doctor.  I've found it very easy to get a lot of other people to change but I've found it enormously difficult... It's funny, isn't it? You know, here I am [in the Department of Health in a public health role] and the people I've had most difficulty getting any engagement with in national policy are the people running public health.'*

While, on the whole, those subscribing to a medical model of health tended to be public health specialists who had undertaken medical training and those who emphasised the importance of a model of public health which focused on wider determinants of health tended to have non-medical backgrounds, this was not consistently the case. It is important to emphasise that many public health specialists (DsPH and RDsPH) were extremely supportive of the need to include a broad mix of skills in the public health workforce.  For example, the following interviewee expressed frustration at the difficulties in getting more non-medically people into public health specialist posts:

SHA: *'I think we've got a long way to go.  I was disappointed that we couldn't get more non-medical people through the appointments' round.  I would have liked to have seen a lot more than we had in our region.  But we've got some really, you know, I think now we're getting, I think there's a better understanding of what multi-*

*disciplinary public health is, and it's a journey – we're not there yet but it's a journey.'*

With the exception of the few interviewees who felt that a multi-disciplinary workforce already existed (see Table 12.1), most of the interviewees suggested it was an area which still required a great deal of further development. As the quotations below illustrate, this was a view evident amongst interviewees occupying a broad range of positions within the field:

SHA [different interviewee to above]: *'What we've actually seen is a move towards encouraging other people from health backgrounds, who are not doctors, into a traditionally medical speciality, to do the same thing, and to have the same perspective that the medics had. So what we're getting is people from nursing and health promotion, generally, coming into public health, and they go through the same training programme, with the same objective, and they come out the end of the sausage machine as similar-ish individuals, but often with a very narrow view of public health because they haven't had the sort of general medical training that medics have. So they don't have anything new to bring, they just have ... what's often a diluted version of what we had before. […] It's a bit of a mindset, you know, I've never heard a public health recruitment panel complain that they've had no accountants or no lawyers or no computer scientists. We're very introspective and look to recruit more of our own, and I would like to see much more diversity, and diversity in every sense.'*

DH: *'I don't think it's yet a reality, no, but I still think, I certainly think it's desirable. I'd like to see people from community development, social marketing, patient and public involvement, people with non-medical backgrounds, as part of the teams. I mean when we talk about multi-disciplinary, we seem usually to mean well using all the various medical disciplines, but I think we need to go beyond the health community…'*

Whilst the above quotations all suggest there is a long way to go before the kind of multi-disciplinary workforce they would like to see is in place, the majority of interviewees were also keen to emphasise that they felt things were at least moving in the right direction. For example:

NGO: *'I think it's getting there. I mean it's certainly a lot closer to that than it was five years ago. Obviously the Voluntary Register has been a big part of that…'*

DH: *'I think it's coming. There have been, I think it's fair to say, some quite big professional barriers put up around some of this stuff, and there was wholesale resistance four or five years ago to anything that looked like a non-medical public health. I think that [still exists] in terms of some old fashioned public health leaders, shall we say. You see it and hear it a bit but it's quite interesting that our head of unit is not medical public health. So I think these are barriers that are slowly being knocked down. And I think if you talk about joint appointments and joint teams within local authorities and across PCTs, it's quite easy to get to a multi-disciplinary workforce. […] So… actually I think there's some way to go but it's going in the right direction…'*

This suggests that recent policy attempts to encourage the specialist public health workforce to broaden its constituency, and to link more closely with actors and sectors beyond the specialist workforce, are having an impact. Bearing in mind that this shift requires some cultural, as well as policy, change and that it is dependent on a range of factors, including changes in training programmes, it is unsurprising that it is not a shift which has occurred quickly.

**12.2 Workforce morale and issues relating to recruitment**

Following the CMO's 2005 annual report, in which he reported that anecdotal information from the NHS 'tells a consistent story for public health of poor morale, declining numbers and inadequate recruitment' (Department of Health 2006; 43), interviewees were asked if they felt this statement was accurate. Almost all agreed that it had been accurate at the time that it was made but opinions differed regarding the extent to which this statement remained true. Only one of the interviewees (a DPH) suggested that morale levels within the public health workforce were currently 'very good' but most felt that the situation had improved significantly since 2005, as the following quotations illustrate:

DH: *'You only had to go to UKPHA, and it was like Depressionsville, wasn't it, around 2004 and 2005? Which was because of the cuts, low morale, low esteem - again, the acute sector trumping everything else. And if you use UKPHA as a barometer of these things, I thought this year's was much more upbeat, much more positive. Many more people there and, I would say, much more positive. When you talk to regional colleagues and local colleagues now, they're much more positive about the emerging agenda. So I think it's pretty much on the up.'*

SHA: *'I think it was definitely a problem last year. I think this year it feels better. I wouldn't say we're all the way there yet, but it does feel ... much improved from where we were before. And so, yes I think we did have poor morale. We lost a lot of good people. But we've got to look at this on the positive side and think that actually this year, and especially with local government engagement, I feel things have picked up a bit, certainly in the last two or three months or so, yes.'*

PCT: *'I think we've been through a difficult twelve, eighteen months and I think part of the problem is, and it's in public health but the whole of the NHS restructuring has taken a long time and that does, inevitably, morale drops and it's very difficult for people coming off training schemes and whatever at that time. So there's certainly been a short term issue about maintaining and supporting public health morale and expertise. But, to be honest, I think we're through that now and there are increasing numbers of public health consultant jobs becoming available.'*

However, a few interviewees still felt the situation remained relatively bleak and that this was largely due to the frequent reorganisations that the public health speciality (and the rest of the NHS) had undergone in recent years (see sub-section 9.3.5), on top of all the problems around funding (discussed in sub-section 9.3.6):

PCT: *'Most people of my generation have given up haven't they? They have not reapplied for their own jobs. Like [Blank] left a few weeks ago, I mean s/he didn't reapply for the job, had his/her arm twisted. [Blank] didn't reapply for his/her own job. You know, people are fed up of doing this. So I've seen lots of colleagues who*

*have just said this is enough, and honestly I'm feeling I couldn't cope with yet another, getting my head around yet another organisation. […] So I think it's really tough keeping morale up now.'*

NGO: *'None of the money that's promised for public health has seen itself through […] I mean it's an absolute scandal. Yes, people are leaving the profession, the cuts are big… have been throughout the system. Morale is very, very low indeed. And also they're worn out with organisational change.'*

NGO [different interviewee from above]: *'I think they are poorly resourced within PCTs, they're poorly staffed, they're under constant pressure, they've probably not got enough resources to do even the basics of the job […] So… I think the workforce is grossly under funded, I think it's under resourced, and for those reasons I think it's very demoralised.'*

It was noticeable that all but two of the public health specialists who were interviewed felt that morale in the public health workforce had recently begun to improve, whilst several of the suggestions that morale was still very low came from people working outside the specialty. It may be that the recent upswing in morale has yet to be picked up by those working outside the speciality itself.

Despite the apparent improvement in morale levels, however, a significant number of interviewees reported that recruitment to public health specialist posts remained problematic. Only one DPH stated directly that there were no problems with recruitment in his/her area and, as the following quotations demonstrate, other interviewees expressed a range of concerns including, once again, both the limited resources available to public health and the difficulties caused by the raft of recent reforms:

NGO: *'There's certainly a real problem around recruitment. […] I can certainly think of some patches where the amount of public health resources are really scarce, and that doesn't help. I mean, I was at a meeting yesterday with a Chief Exec and DPH of a Primary Care Trust where… they've had all sorts of financial issues in their PCT, and so it's inevitably been a real problem in trying to recruit anybody, let alone public health people specifically. […] But the real danger at the moment is that we haven't got people, there is a real scarcity. […] So there's no doubt that, as a specialty, we have got recruitment problems.'*

SHA: *'I think, because we've seen first of all the fragmentation of the specialties and, you know, people having to reapply for their job every couple of years has taken its toll on a lot of the most senior members in public health, and we've seen a real decline in the number of specialists available. […] And obviously that's going to have a big impact, especially as the ones that have left are by and large the most senior, most experienced, who have been through change a number of times and know best how to cope with it, so that's problematic. […] We've [also] got this problem that the new Public Health Directors require a new set of skills, and I don't think that public health was really prepared for that, and I think over the last five years we've failed to train people with the right skills to deliver on the new agenda. And it's been really hard to recruit high quality Directors of Public Health – we just can't find them. […] We see large numbers of specialists now saying they're going to be unemployed*

*because of the MMC process, so maybe that was short sighted, maybe they should have focused more on public health, but still, you know, we've got a quality crisis at the moment, and we've got a potential recruitment crisis in two or three years, due to the gap in numbers of trainees.'*

DH: *'There are lots of adverts, I mean there's no shortage of posts. So what appears to be the problem is the quality and competences of the people who could fill those posts. We seem to have lost a lot of our better people and there isn't the current capacity and capability to create competition for roles etc.'*

A couple of interviewees suggested that the public health speciality had always faced recruitment difficulties and that the current situation might therefore be no worse than in the past. However, most DsPH and RDsPH suggested recent changes had impacted negatively on their ability to recruit people with the skills they were looking for to available posts. Part of the problem, as already discussed in relation to commissioning (see sub-section 10.1.1), was the issue of a possible skills gap within the public health workforce. This is discussed in more detail in the following sub-section.

## 12.3 Perceived gaps in training and issues relating to the current mix of skills within the public health workforce

A number of the concerns relating to recruitment discussed in the previous section resulted from interviewees' perceptions that public health trainees are not being equipped with the skills for the jobs which public health specialists are now being expected to undertake. As the following quotations illustrate, there was a significant level of frustration amongst interviewees based in public health specialist posts about the current mismatch between the focus of training programmes and the content of job descriptions:

SHA: *'If we think that finance is a big issue in public health, as it always seems to be, then why aren't the financial skills of public health much more evident? And we know that collaborative leadership is really important in public health; they have to lead to be able to work across a number of organisations, so why aren't we requiring knowledge of how local authorities work? And why aren't we requiring experience of working in local government as well as the Department of Health, you know, as part of the training? [...] At the minute we're producing a lot of technically fairly able people who don't have the ability to do the jobs that are currently emerging in the new systems.'*

SHA [different interviewee to above]: *'Part of the financial squeeze has been to restrict training budgets, and we've seen a freeze on recruitment into the specialty, and it's over two years now, we've recruited no public health registrars - well it'll be a two year period up in August this year - and that means that we've got a gap in training, which will come to fruition in about three years' time, when there won't be anybody there to fill any empty posts that we can create. And it's not just here; I mean the training programmes have been frozen all around the country. And, again, public health and primary care were seen as soft options – they didn't freeze other specialties in the same way.'*

PCT: *'We're finding in [Blank-city] that people coming through the training programmes are not being short-listed for consultant jobs, and that's got to be wrong. I mean that tells me that the training programmes aren't doing what they were supposed to do which is to train people up to consultant level of expertise.'*

The skills which were mentioned most often as those which public health training courses failed to address but which candidates for specialist posts were expected to possess related to commissioning, collaborative working, leadership, and financial management. Unfortunately, whilst most interviewees felt this was an area which ought to be addressed, few of the interviewees working within the specialism believed current arrangements were adequately dealing with problems. Furthermore, several interviewees suggested that the gaps in training programmes were exacerbated by a lack of clear career development paths for those entering the specialist workforce.

Following the concerns expressed in sub-section 12.2 above, it was also equally unsurprising that many interviewees expressed a desire for changes relating to the training of the public health workforce. Some of these interviewees' comments, such as the following, related to the skills required by the specialist public health workforce:

DH: *'I think we need a fairly fundamental rethink as to what public health, knowledge management and information and analysis is all about in a commissioner-led system. And then it's about what other skills are required and where are those skills best found within or across organisations, and then recruiting against the skills and competences required rather than just vesting it in a title holder.'*

NGO: *'I think the training of public health specialists in this country needs, to be quite polite, a really good kick up the arse. I just don't think that it's producing the sort of public health specialists that we need in the modern world, and I think that some now are struggling with the new ways of working and the new partnership ways of working with the new relationships with local government and with the community and voluntary sector. … we've had conversations about the current agenda in local government and in health, and one particular health trainee, who's very bright, said to me, "Well I've not been trained to do any of this" - and I think that's quite worrying.'*

Others related to the changes required in order to produce the kind of broader workforce that would be able effectively to contribute to public health objectives:

DH: *'You can have a trite statement that public health is everyone's job, well there is something about raising awareness as to how a care assistant could help someone stop smoking or reduce their alcohol intake, so part of it is being embedded across everyone's day to day job. But the reality is that we need our activists, our leaders and our champions and I think they need to be identified, promoted and resourced to be as effective and as enrolled as they can be.'*

Local government: *'I think we need … some of the more creative status to give people a public health interest and role. And I can't quite think of it at the moment, but it does go back to the issue of conceptual development – we've been remarkably uncreative about the way we've talked about this, and we need a very different way of*

*assigning status responsibility and recognition of non-NHS employees who have a public health role.'*

Once again, many of the issues raised in this section relate to broader problems that interviewees focused on in regard to England's current public health system.  In particular, and as already reported upon, the combination of a lack of policy coherence and a high frequency of policy change seems to be a key barrier working against the development of an effectively trained public health workforce.

## 13. Looking to the Future

Interviewees were asked how they would like to see the public health system develop over the next five years and how they felt it actually would develop.  So far the review in the preceding five sections has focused on the main things that interviewees suggested they *would like* to see happen and has compared these to what they felt the current system actually offered.  This section therefore focuses on how interviewees perceived the system was realistically likely to develop in the next five years.

**13.1 How the public health system was likely to develop over the next five years**

When interviewees were asked to suggest how they felt public health in England would actually develop over the coming five years, it was clear that there was a considerable amount of uncertainty over the direction it might take.  In fact, the data suggest that public health is currently at a crossroads (perhaps it would be more accurate to say at *another* crossroads, since the history of public health has been punctuated by a series of crossroads), especially in the light of the arrival of a new prime minister, but also because of the newness of so many recent policy initiatives.

NGO: *'I think the jury's out on what [public health] is quite going to look like but I think the next few months will be absolutely critical in terms of setting the style…'*

SHA: *'I think that [the outlook for public health] will depend upon what happens politically.  I think if we have a change of Government, if we have a Conservative Government, I think that kind of review will happen, but I think the focus will be on probably reducing services and saving money. […] If we stay with a Labour Government, I think it's harder to predict how it will go, because I think in the first two years of a Gordon Brown premiership there won't be an inclination to do anything very radical because there'll be a general election coming up, which will be a contested general election this time, I think. […] But I think, after two years, we would probably see a much more rigorous focus on health inequalities from the centre, and I'm not sure whether that would be delivered through the NHS or through a separate reform.  But there are other issues, I mean at the moment we have the DH capability review, we've got a review of the regional presence of the DH, and all of those may have a big bearing on what happens in the future, so I think it's a very uncertain time, very hard to predict what's going to happen.'*

On a positive note, most of the interviewees were relatively optimistic about the future outlook for public health in England, although their comments were usually hedged with provisos, as the following quotations demonstrate:

SHA: *'I think if we have some stability at the centre and … we get the stability of no more reorganisations, the fact that we've now got local government and PCTs to be coterminous, and government offices and SHAs to be coterminous, I think lends itself to a period of stability and strength that we haven't had. And if that can be held on to then I think the next five years are going to be really good and we can be really focused on some of the changes that we've not been able to do before. If we have another a change of government in two years' time and they come in with a whole set of fresh ideas and we have a whole set of restructuring, then I think we'll just have more of the same.'*

SHA [different interviewee to above]: *'The chances of success are not bad, in the sense that if you have vision, clear goals, milestones, evidence based practice, good performance management, all the things we were talking about before, then you might well get some success. But it has to be in this context of a wider view of how to influence the determinants of health, like poverty.'*

SHA [different interviewee to above]: *'I think we're on a roll actually, I think a lot of the stuff that has been put in place and a lot of the ideas that have been put out into the public domain are getting out there among leaders now, and politicians. So I think the next bit is really about getting the public back into public health, you know, getting people to start thinking about their health more as something that's an asset to them.'*

However, there were also a considerable number of more negative predictions. These came from interviewees based in a range of sectors, as the following extracts illustrate:

DH: *'I think we will go on doing rather more of the same and trying a few of these new strategies, and they mostly won't work, so I bet health trainers will be gone again in another five years - it'll be interesting to know how much we've spent on them - and then we'll have some new ideas which will be not dissimilar from the old ideas. I've sounded terribly cynical about this but…'*

DH [different to interviewee above]: *'I think public health will slip back a bit in the immediate future [whilst it is] very much focussed on the provider/commissioner interface…'*

NGO: *'I see it [the public health system] coming under more pressure, I see it getting squeezed between a strong agenda on local area agreements and further improvements to service delivery for local people. I think it will continue to be under the cosh in the NHS because the big funding's gone now and the NHS is going to have to continue to deliver with no increases in funding, and that is going to put the squeeze on public health, and I can't see a radical change in the sort of targets that the NHS are going to be working on in the next five years and possibly longer.'*

It was noticeable that many of the public health specialists (RDsPH and DsPH) were relatively positive about the future outlook (with the exception of one who was about to retire). Some of them suggested that this may be partially due to the fact that it would be difficult to carry on in a specialist public health role if you were unable to retain a sense of optimism about the future. However, this finding does at least

provide some hope for the future outlook of the public health function.  That said, there are clearly a range of issues which those working within public health (in the NHS and local government) would like to see addressed.  Whilst opinions on many issues varied between interviewees, there are some areas in which the data suggest there exist high levels of agreement about the best way forward.  What is perhaps less clear is whose responsibility it is to try and ensure that the obstacles and constraints reported by our interviewees are addressed.  We reflect on these and other matters in the final section of this review.

## 14. Commentary

In this final section we reflect on the main themes and issues to arise from the interviews that have been extensively reported upon in preceding six sections.  Where appropriate, the commentary also draws on Part 1 of the scoping review, as a means of providing some context to these findings.  In some ways it is unfortunate that this scoping review has taken place at a time when the outlook for public health seems so uncertain, although arguably there is never an ideal, or even optimal, time for such a stock-take since stability and certainty have rarely, if ever, been features of the public health landscape in England and, if the views of the interviewees included in this review are anything to go by, are unlikely to become features in future.   In other ways, at a point of significant potential change, it is probably appropriate to reflect on how the current system has developed, and explore what those working in the system consider is functioning well and what remains to be done.

On the journey that has taken us through the past few decades of the last century and the early years of the present century, what is striking is that many of the key issues facing public health remain so pertinent.  They are reflected in the interviews reported in Part 2 of the review, and also in many of the policy debates around the purpose and nature of public health in modern society, a context in which the role of the 'expert' is questioned and where there is much greater emphasis on individual choice and personal responsibility for health.  Indeed, if there is a defining theme running through the history of public health it is what Berridge has termed a 'preoccupation with occupational positioning' (Berridge 2006: xxv).  Perhaps of significance is the fact that recent major reports from the government's Chief Scientist on obesity (Government Office for Science 2007) and the Nuffield Council on Bioethics (2007) take a much broader cross-government, ecological approach to public health issues and not one which is centred upon the role of the NHS. In so doing, they echo many of the classic reports on public health, notably the Ottawa Charter (1986) and WHO's *Health for All* initiative.

At the end of Part 1, we concluded that the public health community remains fractured and at the mercy of successive NHS reorganisations, each of which seems to have had the effect of further weakening the sector and preventing the development of effective and sustainable partnerships.  Perhaps more importantly, there remains what Lewis (1986) terms an absence of 'philosophical underpinning' at the heart of public health which is reflected in the health politics of 'prevention versus cure' in which 'cure' wins out most of the time in the competition for attention and resources.  The review suggests that many of those working in public health within the NHS today continue to experience the considerable tension that Lewis highlighted in 1986 (ibid: 162) in 'reconciling first their responsibility for the management of health services with that

of analysing health problems and, second, their formal accountability to the NHS bureaucracy with their ethical accountability to their communities'. In many ways, the more interesting and innovative public health work has gone on outside the NHS in local government and among a few NGOs. Unfortunately, however, these efforts have tended to remain piecemeal and patchy.

The issue which perhaps dominates the picture painted in this review is the overriding tension between health care and health and the continuing imbalance between them, to which Wanless and others have pointed. To put it bluntly, we have yet to put health before health care and prioritise health in decision-making across the range of relevant policy areas. This is a difficulty which has plagued public health and our understanding of a public health system which is broader than health care services for at least a hundred years. Yet, despite the persistence of this tension, no resolution appears to be in sight. Until we succeed in shifting the paradigm in favour of health, it seems unlikely that a public health system of the type described earlier in this review can take root. Of course the NHS would form a key part of such a system but it would not seek to be at its centre which, mostly unsuccessfully and unconvincingly, it tries (and is expected) to do at present.

The difficulties over the funding of public health are symptomatic of the dilemma of viewing the NHS as being at the centre of the public health system. Funding issues have plagued the progression of public health priorities for decades. The raiding of budgets in recent years, reported in the interviews, is therefore frustratingly familiar to those who have been involved in the field for some time. Arguments rage inconclusively around whether ring-fencing is the answer or whether this is a sign of weakness and admission of defeat (Wilkinson 2006). If public health were strong, so the argument runs, then why should ring-fencing be necessary? The true measure of commitment to public health must surely be for mainstream budgets to apply to this sector as they do elsewhere in the acute sector. Why should public health be treated as a special case?

There is some basis to this line of reasoning, and a good case to be answered. If the health of the public is deemed important, and if the case for investment in it is regarded as desirable, then the resources should follow. Relying on ring-fencing is a double-edged sword, especially if the resources ring-fenced are not plentiful and constitute a maximum for what is invested when, in fact, the need might be far greater in some contexts. The issues here take us into the territory of what business it is that the NHS, local government and others consider themselves to be in and where public health and related notions of health improvement and well-being fit within these perceptions. All too often, the business of public health is placed in a silo under a DPH who may or may not have 'buy in' from other directors and the board/council of his/her employer (or employers, as in the case of some joint posts). But if public health is seen as central to core business, then all directors and the CEO need to be signed up to it, not just within the NHS but also in other sectors which have a bearing on the health of the public. Clearly the degree to which this happens remains the exception rather than the norm. In part, as many of the interviewees suggested, the answer to such problems lies in workforce development and the acquisition of good leadership skills.

The remainder of this commentary considers the key issues and concerns reported on in Part 2. They are grouped under the following headings:

- the changing policy landscape
- the public health system and its capacity to meet public health challenges
- impact on the public health system of commissioning, partnership working and public involvement
- markets and choice
- the changing public health workforce
- looking to the future.

## 14.1 The changing policy landscape

The key tension to emerge from this scoping review is the lack of certainty and agreement about what the thrust of public health policy and where responsibility for promoting the health of the public across the wider public health system lies. Is the focus on the wider determinants of health or individual lifestyle behaviours? Or is it both? The government seems confused as to where to place the emphasis and this is reflected among those working in public health at sub-national levels. Certainly, the consensus among our respondents is that policy emanating from the Department of Health had shifted towards a greater focus on individual lifestyles and that a proper balance needed to be restored in regard to interventions aimed at a population level as well as at individuals. Even where credit was given to the government for its somewhat limited attempts to address the wider determinants of health, there was disappointment over the failure to openly promote such policies to the public. Instead, interviewees felt that these policies often seemed to be conducted by stealth. However, this approach may change in the light of the Chief Scientist's report on obesity which, as we described earlier, stresses the need for action at a population level (Government Office for Science 2007). It proposes a 'whole systems approach' embracing government (central and local), industry, communities and families and society as a whole. In the light of this and other evidence, the government is reviewing its stance and policies on public health issues, including seemingly ever-widening health inequalities.

Nevertheless, the prospects for achieving a set of integrated policies seem remote in the current context where policy incoherence and the absence of connectivity prevail. The evidence for serious policy incoherence from our interviews is overwhelming. Currently (and recently), there seems to have been a total lack of joined-up policy and management in spite of the Labour government's explicit commitment to joined-up, evidence-based policy-making (Cabinet Office 1999). This renders the public health task problematic if not impossible (see Hunter and Marks 2005). Of course, rational policy-making that is wholly coherent and joined-up is probably the stuff of fantasies (Kavanagh and Richards 2001). Nevertheless, it seems disappointing that at no time in the history of health policy in general, and public health in particular, has the incoherence been so pronounced and so widely commented upon. Moreover, the views of our respondents are amply supported by other independent accounts, notably the Department of Health capability review (Cabinet Office 2007), which has been mentioned on several occasions in this scoping study. If the Chief Scientist's strictures on existing policy responses to obesity (which apply to most other major public health issues) are any guide, then there is a long way to go to secure the

integrated, whole systems approach that it has long been acknowledged public health requires.  The only satisfaction which England can derive from this bleak outlook is that no other country yet has such a policy either though many, like the Netherlands, are grappling with similar issues.

**14.2 The nature of public health and a public health system**

We opened this review with a description of what a public health system should look like.  From our canter through the recent history of public health, and taking account of the evidence from our interviews, England is clearly some way from having such a system in place.  The component parts are all present but they have yet to be assembled in a way that would result in anything remotely resembling a recognisable and well-functioning system.  Certainly the whole is less than the sum of its parts. Factors which continue to hamper progress centre on quite fundamental concerns which have dogged public health throughout its history, namely, definitions of what public health is, the language and terms used to describe it, and the values which underpin it.

The term public health itself continues to exercise concern among practitioners and a significant number of interviewees felt that it remained problematic. Many favoured using specific terms in the context of whether the issue being addressed was one of health improvement, health protection or health inequalities, rather than search in vain for an all-encompassing term which, by its very nature, was always likely to risk confusion.

Clarifying terms and definitions is not a semantic exercise or of purely academic interest since it seems unlikely that unless there is basic agreement over language there can be agreement over what a public health system is.  It matters if there is widespread confusion and a lack of clarity over what public health means, given its use as a short hand term for the health of the public; a range of activities and professions focused on population health; and a discipline with a defined body of knowledge.  The problems of communication arising from the slipperiness and contested nature of the term 'public health' account for much of the estrangement between the NHS and local government (Elson 1999).  Our interviewees expressed a variety of views on both terms – 'public health' and 'the public health system' – and it seems there is little shared understanding of what either stands for.  Perhaps, as we have suggested, there is a need to seek greater clarity concerning their meaning in order to provide some sense of unity to a divided and disparate workforce.  Moreover, conceptual models of a public health system need to reflect the findings of social epidemiology and ecological thinking; an 'ideal type' of public health system would be operationalised through the wide range of organisations and activities which exert an influence on the health of the population.  In the same way, an assessment of the impact on (public) health would form part of decision-making and performance management for all organisations comprising this system.

From a professional perspective, specialists in public health in close association with the Faculty of Public Health have sought to define what the public health function should entail.  Their focus on three domains (see Section 3 above) has been widely accepted, although it has also been contested on the grounds that the three domains do not necessarily all sit easily under a single profession (Hunter 2003).   In addition, the interview data presented in Part 2 of this report suggest that, while this definition is

quite widely accepted by public health professionals, it has had less of an impact on those working in other sectors, many of whom want to see a more encompassing, and less specialist, public health system emerge.

As well as helping to build a common sense of purpose, language and clarity of terminology are important when it comes to establishing a place in a complex organisation (or organisations), bargaining for resources, and working collaboratively. A common understanding of what is being worked towards is essential both for agreeing about commitments to resource input and also for dividing up responsibilities and accountabilities. Furthermore, in the complex types of partnership arrangements that some public health activities are likely to require, a shared understanding of key terms is also essential to organisations, or individuals, seeking to establish a place in a complex partnership. Organisational power can be strengthened, or conversely weakened, by particular understandings of terms. Unfortunately, working against the need for clear and coherent terminology, it can suit parties seeking to create the semblance of consensus to keep the language loose and opaque, which may create the illusion that organisations and individuals with competing interests have each been satisfied. Yet, for those working to implement change at the local level, clarity and explicit agreement concerning definitions and principles are vital in building coalitions and achieving successful outcomes.

Vagueness about the public health function can also result in uncertainty as to where public health professionals might best be located and this remains an issue today, as it has throughout the recent history of public health. Views are mixed as to whether it matters or not. Should the overall responsibility for the health of the public continue to belong to the Department of Health and the Minister for Public Health and her officials, or will this result in preventive health matters continuing to be eclipsed by the immediate demands of clinical treatment? Would the health of the public be more likely to be prioritised if responsibility was located in the new Department for Children, Schools and Family or in the Department for Communities and Local Government? Or is it the prime minister himself, given his personal commitment to ending child poverty and reducing the inequalities gap, who should be held responsible? The interviewees' comments suggest feelings on this matter vary and, indeed, responsibility probably resides with a combination of some or all of these options, which is perhaps as it should be if a public health system is truly to embrace the various sectors and interests which contribute to the public's health. However, there is a risk in thinking about such issues solely in structural terms because, as has been much discussed in this report and elsewhere, issues to do with power, the interplay among vested interests, culture and relationships are all crucial to public health (see Beaglehole et al 2004). A well functioning public health system is not one which needs to have a tidy organisational chart pulling everything together in structural terms but one in which there is some clarity – certainly more than presently exists – over the nature of the tasks and where responsibility for taking action lies.

It would seem that many of these concerns remain alive despite the NHS reforms and recent changes in local government and elsewhere, all of which were supposed to lead to more effective implementation of public health priorities. The lack of coherence around public health aims and goals, which is exacerbated by differing interpretations of key terms, plays an important role here. For example, neither the joint strategic needs assessment underpinning the new commissioning framework for health and

well-being nor the move to put health and well-being partnerships on a statutory footing will work as intended unless there is agreement about language and a genuine sharing of values, perspectives and understandings about what health is.

**14.3 The impact on the public health system of commissioning, partnership working and public involvement**

*14.3.1 Commissioning*

Commissioning for health and well-being is regarded as critical if there is to be real change and a focus on health and well-being.  Yet, it remains a largely elusive activity with which public health practitioners have yet to come to terms.  Certainly, many of our interviewees struggled with the concept, believing it had more to do with secondary care than with public health.  This may seem odd given that commissioning is ostensibly about health improvement with its starting point being an assessment of the health needs of communities.   Joint commissioning between the NHS and local government was supported by some of our respondents although it remains largely uncharted territory and therefore gives rise to uncertainty about what precisely it entails.  Nevertheless, closer joint working between the NHS and local government seems likely in future and is given further endorsement by the emergence of joint DsPH being appointed between PCTs and local authorities.

*14.3.2 Partnership working*

Partnerships are not new and, as all our interviewees reported, are widely perceived to be essential to the successful execution of public health policies.  However, despite the large and growing literature on partnerships in many areas of health and health and social care, we remain remarkably ignorant of whether or not they add value and result in better outcomes for the public (Dowling et al 2004) or for practitioners in terms of allowing them to do their job better.  Great hope is placed on LAAs, which have now been rolled out on a national basis, and the new statutory health and wellbeing partnerships. However, the obstacles facing successful partnership working are not primarily structural and have more to do with issues around differences in culture and values, the distribution of organisational and professional power, debates about resources, and uncertainty about governance and accountability. It is not self-evident that these issues, even where recognised, are being seriously addressed, although the Improvement and Development Agency is grappling with the issue through its healthy communities benchmark tool that is being rolled out in local government.

*14.3.3 Public involvement*

Despite public involvement being in high fashion, and being supported in principle by our interviewees, like commissioning it largely remains elusive.  Most of our subjects felt that public health practitioners had not been effective in engaging the public in decision-making.  However, a desire remained to do better. The problem seemed to lie in an absence of knowledge and skills about how best to involve the public.  Part of the problem comes down to whether practitioners belong to the expert/evidence model of public health or the leader/development model.  The latter has greater resonance

with community development thinking and notions of empowerment. But it is a way of thinking that is novel, if not alien, to many public health practitioners, who are trained as epidemiologists and analysts.

## 14.4 Markets and choice

In recent years, public sector reform in health has pursued a similar direction to other sectors, moving away from a model of traditional top-down central planning towards a model which emphasises local responsibility and the importance of diversity. This new model is expected to be stimulated by market-style competitive principles including the exercise of choice on the part of service users. The belief (or hope) is that such mechanisms and incentives will result in more effective and efficient provision that meets the needs of individuals (Le Grand 2007a).

Most of our interviewees viewed such changes with a high degree of scepticism in regard to the likely impact on public health outcomes. While this does not make such changes wrong in themselves, if those entrusted with their execution remain to be convinced of their efficacy and worth, it does suggest that the implementation of such ideas is likely, at the very least, to be variable. In many ways, these concerns strike at the heart of the criticisms levelled at the Department of Health in the Cabinet Office's (2007) capability review. It concluded that the Department had failed to take key stakeholders with it on its reform journey, that the reform journey itself seemed to lack a clear road map or destination, that the various reforms appeared to have been conceived in separate silos and therefore did not cohere, and that the evidence base for many of the changes either did not exist or had been ignored or selectively drawn upon. There are many lessons here which the Department is required to respond to. But whether the culture of reform, and the style accompanying successive waves of change, established over the last decade can easily be changed may merit its own study. The conundrum is that this very culture is likely to rule out such a study from ever being possible!

The majority of our interviewees expressed concern that allowing greater choice would most likely widen health inequalities rather than reduce them, as some proponents insist. Only a few of our respondents considered choice to be a potential lever to reach the most socially excluded groups and this was often because they conceived of 'choice' in quite different ways from the majority, who were more critical.

When it came to choice of service provider, our interviewees were more comfortable with not-for-profit than with for-profit alternatives. However, there remained doubts about whether such a policy was viable or would make that much difference in practice. The notion of the voluntary sector as being a source of innovation and change in the provision of mainstream as opposed to niche services was treated with some scepticism. There was a concern, too, that for real choice to be available there would need to be spare capacity in the system, which seemed to fly in the face of other pressures to become increasingly efficient (although some key advocates of choice, such as Julian Le Grand, regard choice and efficiency as going hand in hand).

## 14.5 The changing public health workforce

A long-running issue in public health is the degree to which there is a truly multi-disciplinary workforce. From our interviews, it seems that the issue continues to

exercise those working in public health.  In particular, the higher status accorded to medical professionals is seen to be out of kilter with the development of a truly multi-disciplinary workforce.  The general consensus, however, is that while a multi-disciplinary workforce is the right way to go and is taking shape, there remains much more development work to be done to make it effective.  A sound start may be the work completed on multi-disciplinary/multi-agency/multi-professional public health skills (Skills for Health and Public Health Resource Unit 2007).  It is intended as a development tool for both the professional public health workforce and also the wider workforce, and a route map for career development both horizontally and vertically.

Many of the other concerns expressed by our interviewees are rooted in issues to do with the workforce, its morale and its preparedness (or not) for the complex tasks and changes being demanded of it.  Whether there are enough public health professionals is itself a major concern which both the CMO, in his 2005 and 2006 annual reports, and Wanless and colleagues (2007) have separately commented upon, although views taken on this question will reflect how broad a definition of the public health workforce is adopted.  It seems that, while other professional groups have grown in recent years, public health professionals have not.

As important as the number of individuals practising public health within the NHS, if not more so, is the question of whether they are equipped with the requisite skills, especially in respect of leadership and management skills.  From the accounts provided by our respondents, there appear to be major deficiencies and gaps in these areas which also impact on the issue of multi-disciplinarity considered above.  Despite knowing about many of these issues for years (Hunter 2002), little has been done to address them in a sustainable fashion.  Short-term, quick, one-off initiatives are supported from time to time but there has been a singular lack of proper long-term investment of the type that is being called for.

The leadership challenge in contemporary public health is a complex one. A focus on leadership alone tends to highlight the role of individuals and the part played by heroic leaders in securing change.  Given the complexities and interconnectedness of modern public health challenges, a reliance on heroic individuals is therefore neither appropriate nor possible, even if it were desirable.  Effective leadership for health demands a sound grasp of change management principles and skills, and these have not, for the most part, been well understood or developed in the public health workforce.  These deficits are at last, if slowly, being acknowledged and action is being taken to address them.  Some English health authorities have introduced leadership for health improvement programmes based on a model piloted in Yorkshire and Humber SHA (Hannaway, Hunter and Plsek 2007).  NHS Education for Scotland has also recently introduced a pioneering leadership programme targeted at frontline practitioners (http://www.nes.scot.nhs.uk/nursing/healthimprovement/).  Based on the Leadership for Health Improvement Programme piloted in Yorkshire and Humber SHA, it represents an approach from which England could in turn learn.  Finally, the Department of Health has commissioned a scoping review of public health leadership programmes with a view to identifying gaps and to determining what action might be taken to address these.

A distinction is often made between leadership and management and, though this has some appeal, it may be unhelpful.  The point has been made that leadership and

management are not mutually exclusive – managers have to lead and leaders have to manage. In Mintzberg's words, 'management without leadership is sterile; leadership without management is disconnected and encourages hubris' (Mintzberg 2004: 6). From our interviewees' comments and observations it seems that much more attention should be given to how leadership and management functions can proceed *in tandem* since many of the weaknesses of the current public health system seem to be a result of managerial weaknesses. The principles underpinning the successful 'leadership for health improvement' programme, mentioned above, may offer a way forward. These leadership attributes apply across sectors and need to be married to public health values if a change in the priority attached to the health of the public is to be achieved and a well-functioning public health system is to be created and sustained.

### 14.6 Looking to the future

Mixed views were expressed by our interviewees on what the future holds for public health. Overall, there was optimism but it was mixed with considerable concerns over funding issues and over remaining within an NHS which, interviewees felt, was likely to come under greater pressure in future years if (as expected) the period of generous financial growth comes to an end. At the time of writing, in part following a more generous comprehensive spending review settlement, the NHS has a £2 billion surplus and many in public health are experiencing something of a windfall in respect of additional resources. But it is unlikely that such a situation will be maintained for long, unless there is real and sustained contraction of acute care services as intended through the Darzi review, or that spending resources urgently before the financial year-end is a sensible way to achieve improved health.

Concern was also expressed by our interviewees at the dysfunctional impact of continuing policy incoherence and new initiatives. On a more optimistic note, many of the interviewees felt that a new awareness and interest in public health issues amongst those based in local government provided hope for the future. There was a sense that the role of local government in addressing public health issues and providing local leadership was an idea whose time had come.

## 15  Conclusion

It is not the purpose of this scoping study to make recommendations. What we were commissioned to do, and hope to have achieved, is to provide a review of the state of public health in England over the past 30 years or so and to chart where it might be heading in the next few years, at a time when public health issues have never been higher up policy and political agendas. In doing this, we hope to have provided a useful platform from which to launch the various research studies that have been funded in the National Institute for Health Research SDO's first public health research call (summaries of the studies can be visited at the SDO's website: http://www.sdo.lshtm.ac.uk/cppublichealth.html). In their different ways, each of the studies supported should be able to assist either with finding solutions to the problems we have identified in our scoping study or by contributing important insights and new understandings of some of the concerns we have commented upon.

Unfortunately, prominence of public health issues on the policy agenda has not generally been matched by successful results or achievement, although there are notable, if few, exceptions, such as the ban on smoking in public places.  An effective public health system would reflect a clear sense of value and of purpose across a range of organisations capable of influencing the health and well-being of the population at national and local levels. Public health professionals remain ill at ease with themselves and uncertain of their identity, purpose and ability to manage change. The NHS continues to dominate health policy, as it has done pretty well without interruption since its inception almost 60 years ago, and, as a result, pulls the policy focus towards ill-health and health care services.   With the government's enthusiastic embrace of market principles and private sector solutions, there is widespread suspicion that different policy objectives are moving in opposing directions: for example, widening inequalities in one direction (income differentials) while prioritising them in another (through PSA targets).  With the mantra of choice everywhere, the danger of a shift in focus towards individual lifestyles and behaviour is that a narrow, 'victim-blaming' (Crawford 1977) ethos will return, under the guise of individual empowerment through choice.  Yet, as the Foresight report on obesity warns, policies aimed solely at individuals and at short-term initiatives seemed destined to fail.

The central contradiction running through health policy is nicely captured in the following quotation from a senior official in the Finnish Ministry of Social Affairs and Health: 'one of the great paradoxes in the history of health policy is that, despite all the evidence and understanding that has accrued about determinants of health and the means available to tackle them, the national and international policy arenas are filled with something quite different' (Leppo 1998).  Many of the views of our interviewees, reported in Part 2 of this review, bear testimony to this paradox which, give or take the occasional deviation, remains alive and largely unresolved. Its impact is insidious as it corrupts any alternative conception of what a health system is or could be.  Policy in what Kickbusch (2007) calls 'health societies' still frames 'health' in terms of expenditure and consumption of health care services and there is little differentiation between programmes that focus on health and those that focus on health care. Indeed, as Coote (2007: 138) claims, 'Health policy has been so thoroughly skewed towards illness and services that a visitor from out of space could be forgiven for assuming that the main role of government in this field is to fund and manage vast armies of doctors and nurses in hospitals up and down the country, all striving to repair sick bodies.'   The problem is that once in post, those vast armies of doctors and nurses become powerful vested interests lobbying for more resources and extending their reach.

We need to consider and confront why health policy continues to be skewed towards treatment and illness services. As noted, powerful vested interests remain in place to ensure that the NHS remains an illness service (see, for example, Law, 2007).  Setting the rhetoric to one side, little real and sustained effort is made to reduce demand by keeping people healthy, although the world class commissioning initiative just launched in England represents another attempt to do so.  To this extent, many of those working in public health are themselves victims of a system not of their making or choosing, and one whose incentive structure is such that it operates largely in favour of maintaining the status quo. It is therefore unreasonable to assume that resolving the many weaknesses within the public health system which we have

identified and reviewed in this scoping study would somehow miraculously change the power balance in health policy. Many of these weaknesses are a reflection of the entrenched bias in health policy towards health care services. Even when attempts are made to address public health issues, they generally fall short of what is needed because they tend to focus on measures to alter individual lifestyle rather than tackle the social, economic and cultural circumstances shaping people's lives. If leadership is a weakness within the public health system, which, based on the interviews undertaken and host of other evidence, we have argued to be the case, it is a weakness at the highest political level as well as at other levels. Political leadership is needed to bring about the required shift in emphasis in policy so that treatment services do not forever eclipse sustainable investment in public health measures.

Our findings suggest that, unless there is some structured discourse around what public health is, what a public health system entails, and why it has failed to meet expectations in the light of a mobilisation of bias in favour of health care services, then it is unlikely that major advances can be achieved. Even if we can begin such discussions, there is little doubt that we remain a long way off the step change called for by Wanless (2002; 2004) when he put forward his notion of a 'fully engaged scenario'. As discussed in Part 1, the 1986 Ottawa Charter, which has stood the test of time well, provides a framework within which such a debate may be conducted. Revisiting the Charter, the International Union for Health Promotion and Education and the Canadian Consortium for Health Promotion Research have both proposed, 'recommitment to the ideas of the Ottawa Charter and strengthening the conditions for effective health promotion are urgent matters. Health inequalities within and between nations are increasing worldwide' (Scriven (ed) 2007: 3). The notion of healthy public policy being implemented through a public health system remains valid, although it has yet to be realised and often remains little more than worthy rhetoric.

Yet there are glimmers of hope. The prognosis is not completely gloomy or without optimism; the government has sought to act on the wider determinants of health, albeit with apparent reluctance at times, and occasional timidity. There is also the prospect of further change and progress as a result of various other developments. Three, in particular, merit some brief, concluding comments.

First, as reported earlier in Part 2, the government in England is reassessing its health policy and stance on health inequalities and an announcement is due next year. The Department of Health is also committed to securing more effective joined-up working across government. These developments may come to nothing and may fall short of what is required but they do represent modest opportunities to take heed of some of the issues, concerns and hopes expressed by our interviewees.

Second, the European Union, during the time of the Finnish Presidency in the second half of 2006, has signed up to the notion of Health in All Policies (HiAP) which, though not a new concept (having its origins in the Ottawa Charter), has been given a new lease of life. HiAP is viewed as a natural continuation of Finland's long-term horizontal health policy. It is proposed as a strategy help strengthen the link between health and other policies by addressing 'the effects on health across all policies such as agriculture, education, the environment, fiscal policies, housing and transport. It seeks to improve health and, at the same time, contribute to the well-being and wealth of the nations through structures, mechanisms and actions planned and managed

mainly by sectors other than health' (Stahl et al 2006: xviii). HiAP is not confined to the health sector and public health community but is a complementary strategy focusing on health determinants as the bridge between policies and health outcomes. The notion of strengthening the link between health and other policies is entirely consistent with the concept of a 'public health system' or, perhaps, in Kickbusch's (2007) term, a 'health system'.

Third, as a result of political devolution within the UK to Scotland, Wales and Northern Ireland, there are moves to do things differently in the devolved polities and, consequently, an opportunity for England to learn from developments taking place close to home. The health sector is a good example of where differences are becoming more apparent between the four countries making up the UK. The smoking ban in public place is perhaps the most striking example of this, where the lead came from Scotland. Indeed, it is quite conceivable that England would not have gone down a similar road without that lead and the pressure to follow suit which resulted from it. Since then, Scotland has gone further and has recently restructured its governmental arrangements, departments and ministerial portfolios to reflect a greater determination to tackle cross-cutting issues which demand a joined-up response across government. In all but name, such developments come close to realising the notion of a public health system, and bring together the overlapping agendas of public health, sustainable development and social justice. Such experimentation may, of course, be easier in a small country but, nevertheless, it seems likely the same principles may be adapted to fit different circumstances.

In order to push health policy and the public health system forward in England in the direction desired by many, if not all, of our interviewees, as well as by many observers and analysts over the years, perhaps the advocacy role of public health professionals requires strengthening. This was, indeed, suggested by a few of our interviewees, along with others within the public health community. As Mackie and Sim (2007:641) point out: 'if we accept that being in public health requires us to be advocates for the health of the population we serve, then we should be adept in the art of rhetoric. We should be highly skilled persuaders of people, politicians and society as a whole to protect and promote the public health'. In similar vein, Kickbusch (2004: 468) believes that public health must once again 'become an art and a science', a discipline that is 'fully engaged in the political and social arena' and mixes 'wild passion' with reasoned analysis and sound evidence.

It seems, however, that advocacy from public health professionals is in short supply when there remains so much anxiety around the public health function – what it means, where it should be located, who should assume responsibility for outcomes, where the means to take the necessary actions are, or should be, located, and so on. If public health is not going through another 'crisis' exactly, neither is it in the healthiest of states. If we are to meet the health challenges already known to exist, as well as those that will, in all probability, arise in future (*ph.com* 2007), then those responsible for the health of the public need to raise their sights well above what Wanless et al (2007) call 'piecemeal, often modest initiatives'. The notion of a public health system has appeal in terms of showing what the public health function could aspire to become but, as our study shows, England is some way from having such a system in place. There are also few signs of the political leadership needed to ensure that, even when public health is accorded priority, it receives it.

# Appendix 1: NHS Reorganisation – 1975-2007

The numerous reorganisations of the NHS since 1974 have each raised questions over the location and concentration of public health resources, the key responsibilities of public health professionals, and their capacity to work effectively across health and local authorities, across regions and with primary care. The brief summary below illustrates these points; diagrams are used to capture organisational snapshots within the various changes between 1974 and now.

**Pre 1974 NHS: Medical Officer of Health**

Up until 1974, the Medical Officer of Health (MoH) was based in local government, responsible for the health of the local population and the administration of community health services, including family planning, environmental health services, health visiting and health centres. The Health Education Council was formed in 1968 as a non departmental body registered as a charity. The specialty of community medicine was formed in 1972, heralding its future role in the NHS

**Diagram 1:**
*The pre-1974 NHS (reproduced from Draper, Grenholm and Best, 1976)*
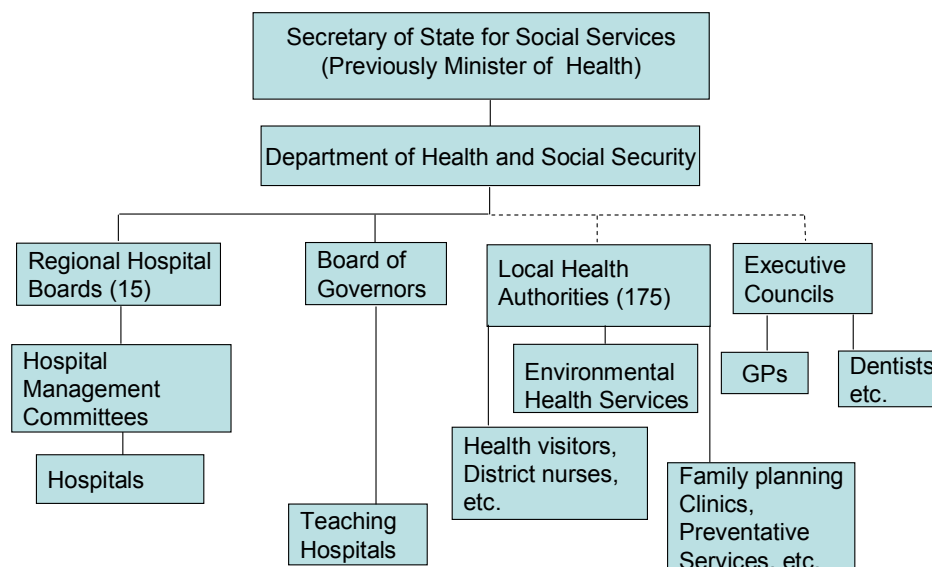


**1974-1982: Community physicians based in district health authorities**

With the 1974 NHS reorganisation and the creation of Regional, Area and District Health Authorities and Community Health Councils, MOsH were replaced by Community Physicians, located in the new District Health Authorities as District Medical Officers or Specialists in Community Medicine and in Area Health

Authorities (AHAs), where they became increasingly involved in management and administration. For the first time, personal health services and environmental health services were separated. The former Executive Councils were replaced by Family Practitioner Committees; AHAs corresponded to the new local government boundaries (outside London); health education departments were accountable to AHAs. However, joint consultative committees were also formed across the NHS and local authorities to promote partnership working.

**Diagram 2:**

*The 1974 NHS (reproduced from Draper, Grenholm and Best, 1976)*
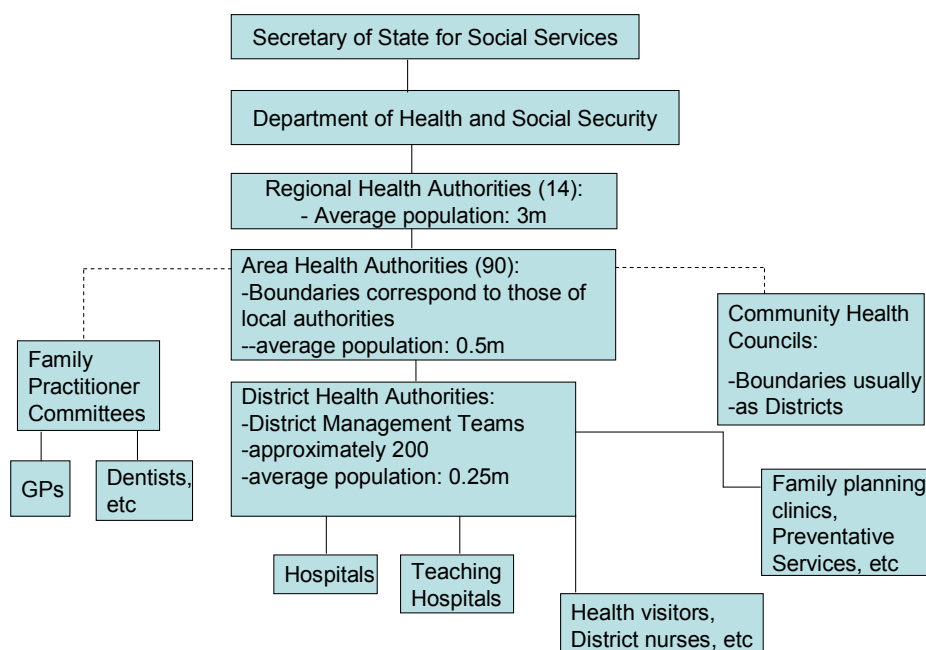


**1982 -1989: From community medicine to directors of public health**

In 1982, the tier of management represented by AHAs was replaced by 192 restructured District Health Authorities (DHAs). Elected local government members formed part of their membership. In 1984, general management was introduced and, in 1986, the NHS Management Board was established. In 1989 this was reorganised into the NHS Policy Board and the NHS Management Executive. In 1988, the Department of Health split from the Department of Health and Social Security. It was recommended (Acheson 1988) that each DHA appoint a Director of Public Health, that the term community medicine be replaced by public health medicine, and that the annual report of the MoH be resurrected.

In 1985, Family Practitioner Committees (FPCs) became autonomous bodies, accountable to the Secretary of State for Health. Collaboration across FPCs and DHAs, although essential for planning services, remained problematic. The Health Education Authority was established as Special Health Authority within the NHS in 1987, now directly accountable to the Secretary of State for Health.

**1989 -97: Purchasers and providers**

Following the white paper, *Working for Patients* (1989), which established the purchaser-provider split in the NHS, the internal market was introduced in 1991 and, from 1991-5, stand alone NHS Trusts were created. DHAs became Health Authorities (1991) with business style management boards and responsibility for commissioning services and assessing health needs. DsPH became involved in purchasing. Also in 1991, FPCs became Family Health Service Authorities (FHSAs), coterminous with the Health Authorities. In 1996, Regional Health Authorities were reorganised and reduced in number from 14 to eight. They were known as Regional Offices of the NHS Executive. In 1994, nine Government Offices were set up, one for each region in England, although there was a lack of coterminosity between the regional offices of the NHS Executive and Government Offices.

HAs took on a number of public health functions previously undertaken by the regional offices (eg surveillance). While each regional office had a regional director of public health, they no longer published annual reports.

In 1996, FHSA responsibilities were merged into those of health authorities. Responsibility for health strategies rested with the HAs. It was argued that a fragmentation of purchasers and providers would make coordinated planning more difficult.

**Diagram 3:**

*The 1996 NHS*
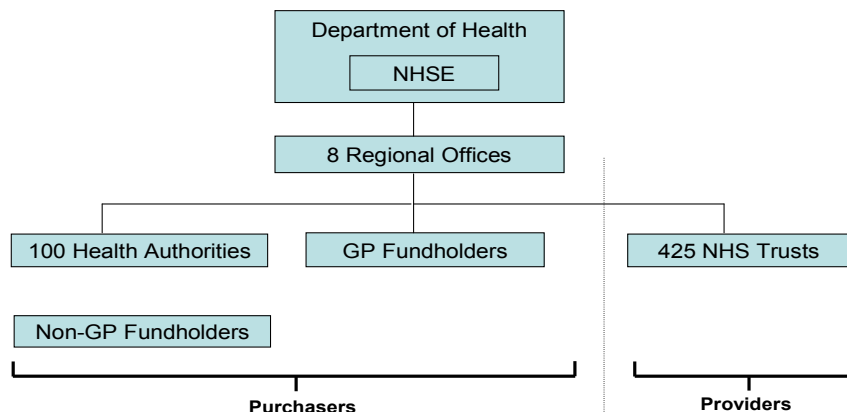


**1997 – 2007: From health authorities to primary care trusts**

In 1999, following publication of the white paper, *The New NHS: Modern Dependable,* in1997, 481 Primary Care Groups (later Primary Care Trusts) were established. HAs were tasked with producing three year Health Improvement Programmes, in collaboration with Primary Care Groups and local authorities, drawing on the Director of Public Health's Annual Public Health Report and in the

context of the public health strategy, *Saving Lives: Our Healthier Nation*, published in 1999. In 2000, the first wave of PCTs was established and, in 2001, *Shifting the Balance of Power* (2001) announced that 302 PCTs and 28 Strategic Health Authorities would replace the 95 health authorities and the nine regional offices of the NHS Executive; this was completed in 2002. Regional Health Authorities were abolished and Regional Directors of Public Health were based at Government Offices while both SHAs and PCTs had Directors of Public Health. In 2003, the four Regional Directorates for Health and Social Care were abolished. The Health Development Agency was established as a special health authority in 2000 and the Health Protection Agency was established as a Special Health Authority in 2003.

**Diagram 4:**

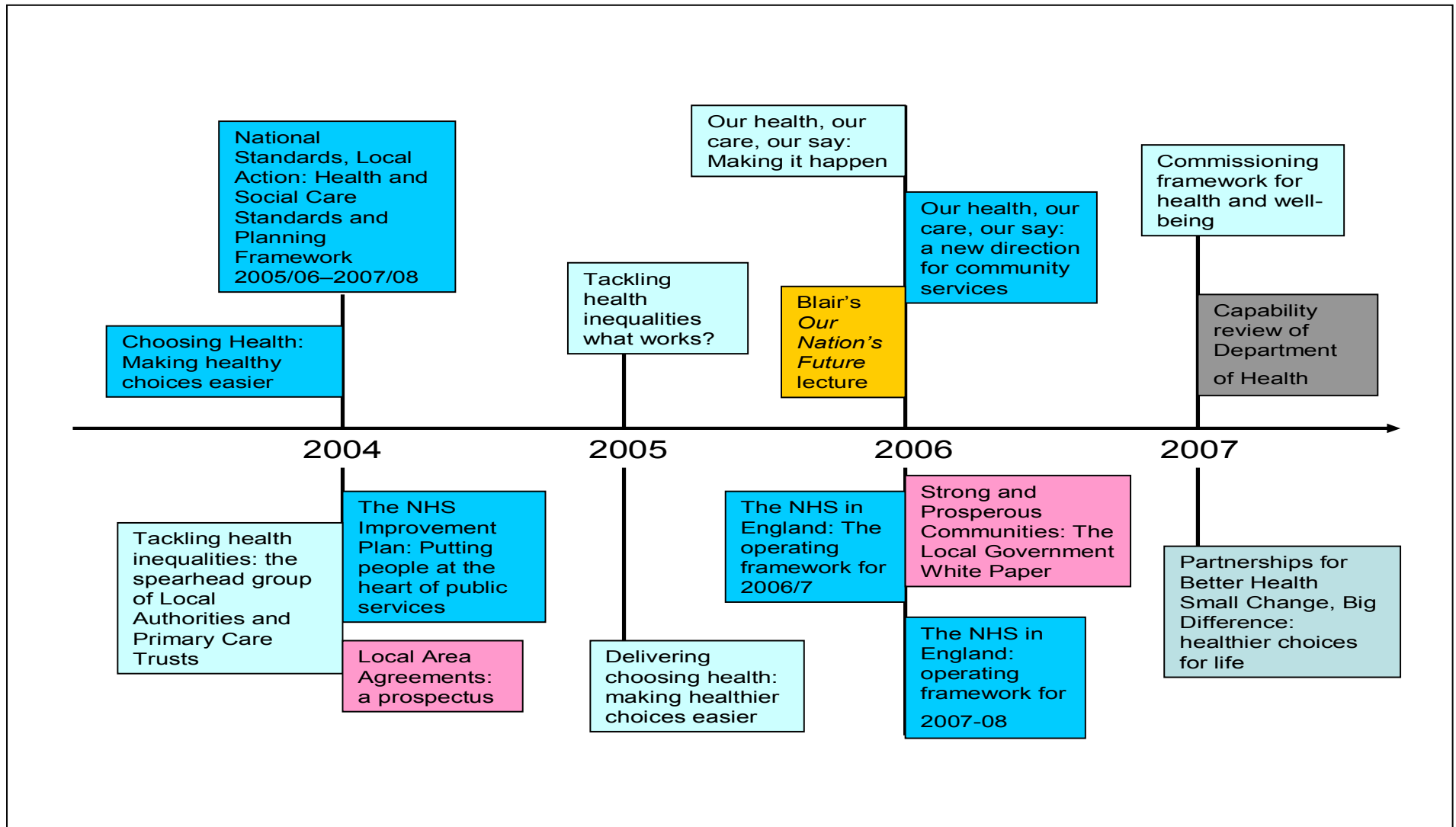*The 2004 NHS (adapted from Department of Health, 2004)*
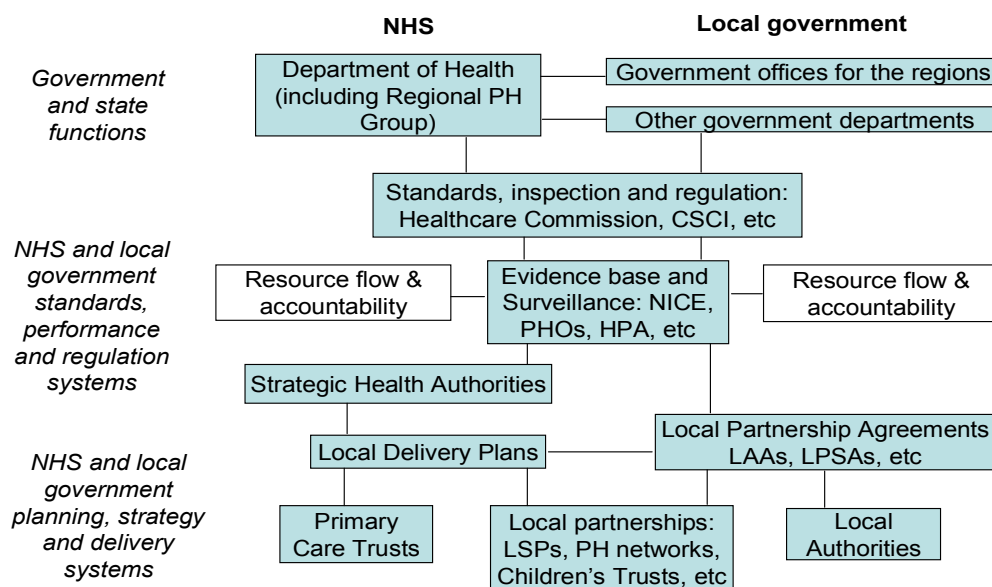


**2005 –present: More reconfiguration**

Following publication of *Commissioning a patient-led NHS* in 2005, Strategic Health Authorities were reconfigured (in 2006) to match the boundaries of Government Offices, reducing their number from 28 to 10. Primary Care Trusts were reduced in number from 303 to 152 (mirroring the number of the former District Health Authorities) and the majority were designed to be coterminous with local authorities. In 2006, a single director of public health post was established at regional level, combining the remits of Regional Director of Public Health, Strategic Health Authority Director of Public Health and Medical Director posts. At PCT level, encouragement was given to making the DPH a joint post between the NHS and local government and by early 2007 most of the new DPH appointments were joint although the term 'joint' could mean very different things in different health

communities. The Health Protection Agency was established as a non departmental public body in 2005 accountable through the Department of Health. The Health Development Agency was subsumed within the National Institute for Clinical Excellence in 2005 which was renamed the National Institute for Health and Clinical Excellence while retaining the acronym, NICE.

**Appendix 2: A time line of key public health policy statements since 2004**



National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06–2007/08

Our health, our care, our say: Making it happen

Commissioning framework for health and well-being

Our health, our care, our say: a new direction for community services

Choosing Health: Making healthy choices easier

Tackling health inequalities what works?

Blair's *Our Nation's Future* lecture

Capability review of Department of Health

2004     2005     2006     2007

Tackling health inequalities: the spearhead group of Local Authorities and Primary Care Trusts

The NHS Improvement Plan: Putting people at the heart of public services

The NHS in England: The operating framework for 2006/7

Strong and Prosperous Communities: The Local Government White Paper

Partnerships for Better Health Small Change, Big Difference: healthier choices for life

Local Area Agreements: a prospectus

Delivering choosing health: making healthier choices easier

The NHS in England: operating framework for 2007-08

## Appendix 3: Interview Schedule

**Introduction**
**1**. We are carrying out a series of interviews with key stakeholders to inform the second phase of a scoping study of the public health system in England. This study is funded by the NHS Service Delivery and Organisation (SDO) Research and Development Programme.

**2.** This part of the study will explore:
- the degree of 'fit' between the evolving public health system and public health challenges it needs to address;
- the implications for public health service delivery of national policy priorities;
- the impact of recent policy reforms on the management, organisation and delivery of public health services;
- the changing composition and shape of the public health workforce.

**3**. Approximately 25 interviews are being carried with key stakeholders across England. All interview data will be anonymised and identities of the interviewees will be confidential. The full report will be completed and submitted to the SDO in September 2007, and a copy will be sent to all interviewees upon publication.

4. The aim of this interview is to find out about your personal opinions and experiences in your own area. Ideally, we would like to record the interview and transcribe it in full. The transcript will then be anonymised to ensure speakers are not identifiable. Are you happy with this arrangement?

**Interview Schedule**
*(Note the interview schedule may need to be amended to reflect particular interests of interviewees.)*

**A. The first section is concerned with the public health system and its capacity to meet public health challenges.**

A1. What do you understand by the term 'public health system'?

A2. What would you say are the hallmarks of an effective public health system?

A3. Which values do you think should underpin a public health system?

A4. In a major speech on public health in July 2006, Tony Blair stated that 'our public health problems are not … public health problems at all. They are questions of individual lifestyle'. To what extent would you agree with this assessment?

A5. It has been argued that an emphasis on lifestyles and individual choice increasingly predominates over a concern with the material and structural causes of ill health. Do you consider this to be the case? If so, why?

A6. It has been argued that the current blend of targets and incentives encourages a downstream approach to public health interventions. Do you consider this to be the case?
If so, what is your view of this development?

Prompt
- Statin prescribing as a route for meeting the 2010 health inequalities target?

A7. In your view, how suited is the evolving public health system for addressing current public health challenges?

A8. The CMO has argued in his 2005 Annual Report that the prevention of premature death, disease and disability is often seen as 'an option not a duty'. What, in your view, are the most important levers for promoting proactive approaches to public health?
- At local level?
- At regional level?
- At national level?

A9. Do you consider the term 'public health' at all problematic? If so, which alternatives would you prefer? What are the reasons for your choice?

Prompts
- Do you feel the term is similarly understood across different sectors (local government, NHS, etc)?
- Health and well-being?
- Health improvement?

A10. Is there anything further you would like to add about the public health system and its development?

**B. The second section explores implications for organising and managing public health of national policy priorities: commissioning for health and well being; public health partnerships; and public involvement.**

B1. Government policy is currently encouraging a strategic shift towards health and well being (as reflected in the recent *Commissioning Framework for Health and Well Being* (DH) and the Local Government White Paper *Strong and Prosperous Communities*).

Do you think that this policy will be successful? If not, what do you consider the likely barriers to implementing this policy?

B2. Could you describe any factors which, in your view, enable effective commissioning for health and well-being in **your PCT/region?**

Prompts
- Joint needs assessment?
- Leadership skills?

- Business planning skills?
- Quality of information?

B3. Could you describe any factors which, in your view, act as barriers to effective commissioning for health and well being **in your PCT/ region?**

Prompts
- PCT resource constraints?
- Public health lack of capacity?
- Practice-based commissioning?
- General practice and the QOF?
- Diversity of provision in primary care and the creation of a market?
- Downstream emphasis?
- NHS as lead agency for public health?
- Other?

B4. How well do you feel partnerships for public health are working **in your area**?
- Joint DPH appointments across PCTs and local authorities?
- SHAs and Government Offices more closely aligned?
- Health and well-being partnerships at local level (under the LSP)?
- Joint arrangements for strategic needs assessment?
- Joint responsibility for Local Area Agreements and PSA targets?
- Joint funding and accountability?

B5. What difference, if any, do you think coterminosity of boundaries will make
- At local level (between PCTs and LAs)?
- At regional level (between SHAs and GoRs)?

B6. What are the funding arrangements **in your area** for joint DPH appointments?

B7. What, if any, would you say are the current obstacles to more effective public health partnerships **in your area**?

Prompts
- Accountability?
- Remit?
- Governance?
- Culture
- Resources
- Trust

B8. How do you think the obstacles you have cited might be overcome?

B9. What role, if any, do you think the public should play in influencing commissioning priorities for public health and health improvement?

B10. How could this be achieved if it isn't already?

B11. Do you think the balance of incentives and targets reflected in the performance management framework promote each of the three themes above, that is
- commissioning for health improvement and the reduction of health inequalities?
- public health partnerships and collaborative working?
- public involvement?

*C. The third section focuses on the impact of current NHS reforms on public health.*

C1. Increased choice through provider diversity, decentralisation and the introduction of a competitive market place underlies many recent NHS reforms. What do you feel the impact of the choice agenda is likely to be on:
- Longer term planning for health improvement?
- Public health partnerships?
- Inequalities in service access and provision?

C2. It seems likely that the third sector will gradually play an increased role in providing publicly-funded services. Do you agree that this is the case? If so, what impact, if any, do you think this is likely to have on services for health improvement and addressing health inequalities?

C3. How would you describe the current impact (in your PCT/region/nationally) of NHS reforms arising from *Commissioning a patient-led NHS* on:
- Public health budgets?
- Funding available for implementing 'Choosing Health'?
- The role of directors of public health and public health teams in PCTs?
- Public health management arrangements?

C6. Is there anything further that you would like to add about the current public health system and the impact of recent developments?

*D. The fourth section concerns the public health workforce*

D1. In his 2005 report, the CMO comments that anecdotal information from the NHS 'tells a consistent story for public health of poor morale, declining numbers and inadequate recruitment'. Do you think that this applies in **your region/area?**

D2. Do you think a multi-disciplinary public health workforce is a reality? How do you think it could be encouraged?

D3. What changes do you think need to be in place if your region/PCT is to develop:
- A public health workforce that matches public health challenges?
- A public health orientation in the wider workforce?
- Effective public health networks?

*E. The final questions concern the future development of the public health system.*

E1.  How would you like to see the public health system develop over the next five years?  How do you think it will develop?


## *F. Request for information*

F1. Are there any local documents that you could send us that would shed light on any of the issues we've covered in this interview?
- Are they in the public domain (i.e. would it be OK for us to refer to them in any reports we write)?

F2. Are there other key individuals you can think of whom it might be useful for us to contact?

Feedback on interview process?

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